



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](#)

09/03/2017

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad Biography	Plaid Cymru The Party of Wales
Dawn Bowden Bywgraffiad Biography	Llafur Labour
Angela Burns Bywgraffiad Biography	Ceidwadwyr Cymreig Welsh Conservatives
Caroline Jones Bywgraffiad Biography	UKIP Cymru UKIP Wales
Dai Lloyd Bywgraffiad Biography	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Julie Morgan Bywgraffiad Biography	Llafur Labour
Lynne Neagle Bywgraffiad Biography	Llafur Labour
Lee Waters Bywgraffiad Biography	Llafur (yn dirprwyo ar ran Jayne Bryant) Labour (substitute for Jayne Bryant)

Eraill yn bresennol
Others in attendance

Michelle Fowler	Tyst Witness
Beti George	Tyst Witness
Craig Hathaway	Myfyriwr meddygol, Prifysgol Abertawe Medical student, Swansea University
Nigel Hullah	Tyst Witness

Emily Jones	Tyst Witness
Karen Kitch	Tyst Witness
Yr Athro/Professor Keith Lloyd	Deon Ysgol Feddygol Prifysgol Abertawe Dean of Swansea University Medical School
Madeline Phillips	Tyst Witness
Dr Stephen Riley	Deon Ysgol Feddygol Prifysgol Caerdydd Dean of Cardiff University Medical School
Yr Athro/Professor Ian Weeks	Pennaeth Gweithredol yr Ysgol Feddygol, Prifysgol Caerdydd Acting Head of the School of Medicine, Cardiff University

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

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

Dechreuodd y cyfarfod am 09:17.
The meeting began at 09:17.

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

[1] **Dai Lloyd:** Croeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1, cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiant, a allaf i gyhoeddi bod Jayne Bryant wedi cyflwyno ymddiheuriadau? Ac mae hi wedi esblygu i fod yn Lee Waters, felly croeso i Lee Waters i'r cyfarfod hwn y bore yma. Gallaf i ymhellach egluro i bawb, yn amlwg, bod y cyfarfod yma'n ddwyieithog. Gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i hefyd atgoffa pobl, yn cynnwys y Cadeirydd, i ddiffodd eu ffonau symudol ac unrhyw offer trydanol arall sy'n gallu ymyrryd efo'r offer darlledu? Nid ydym yn disgwyl tân y bore yma, felly os bydd yna larwm yn canu, rydym yn cael ein cyfarwyddo i ddilyn y tywyswyr i adael yr adeilad mewn modd boddhaol.

Dai Lloyd: Welcome to the latest meeting of the Health, Social Care and Sport Committee here in the Welsh Assembly. Under item 1, introductions, apologies, substitutions and declarations of interest, can I just say that Jayne Bryant has given her apologies? And she has now evolved into Lee Waters this morning, so welcome, Lee, to this meeting. Can I also explain to everyone that this meeting is bilingual? You can use the headphones to hear Welsh-to-English simultaneous translation on channel 1, or you can have amplification on channel 2. Can I also remind people, including myself, to turn off their mobile phones and any other electronic equipment, because it can interfere with the broadcasting equipment? We are not expecting a fire alarm this morning, so if you do hear the alarm then please follow the directions of the ushers out of the building in an orderly fashion.

09:18

Ymchwiliad i Recriwtio Meddygol—Sesiwn Dystiolaeth 10—Ysgolion
Meddygol Cymru
Inquiry into Medical Recruitment—Evidence Session 10—Medical
Schools in Wales

[2] **Dai Lloyd:** Felly, symudwn **Dai Lloyd:** Moving on, then, to item 2,

ymlaen i eitem 2: sesiwn dystiolaeth 10 ar yr ymchwiliad i recriwtio meddygol. O'n blaenau ni mae gyda ni dystion y bore yma o ysgol feddygaeth Prifysgol Caerdydd ac ysgol feddygaeth Prifysgol Abertawe. Efallai y dylwn i ddweud ar y dechrau fel rhyw fath o ddatgan buddiant fy mod i yn bersonol wedi graddio un tro o ysgol feddygol Cymru yng Nghaerdydd ac mae fy mab hynaf wedi graddio ryw dair blynedd yn ôl o ysgol feddygol Abertawe. Felly, mae hynny ar y record. Felly, gyda hynny o gyflwyniad, a allaf i felly groesawu Dr Stephen Riley, deon addysg feddygol ysgol feddygaeth Prifysgol Caerdydd, yn ogystal â'r Athro Ian Weeks, pennaeth ysgol ysgol feddygaeth Prifysgol Caerdydd, yn ogystal â'r Athro Keith Lloyd, sydd wedi bod o flaen y pwyllgor yma eisoes, ond mewn rôl wahanol heddiw fel deon a phennaeth ysgol feddygol Prifysgol Abertawe? Ac hefyd, croeso i Craig Hathaway, sydd yn fyfyrwr meddygol yn ysgol feddygol Abertawe. Rydym wedi derbyn eich adroddiadau ysgrifenedig, ac wedyn mae'r cwestiynu yn seiliedig ar beth rydym wedi'i glywed yn y naw sesiwn dystiolaeth cyn hon, yn ogystal â'ch deunydd ysgrifenedig. Felly, heb fwy o siarad, fe awn ni'n syth i'r cwestiynu. Nid oes rhaid i bawb ateb pob cwestiwn, gyda llaw, achos yn y bôn, awr sydd gyda ni. Nid ydym yn mynd i fod yma drwy'r dydd. Rydym yn mynd i ddechrau efo Dawn Bowden.

please: this is evidence session 10 on the inquiry into medical recruitment. Before us we have witnesses from Cardiff University school of medicine and Swansea University medical school. Perhaps I could, as some sort of declaration of interest at the beginning, say that I personally did graduate a long time ago from Cardiff medical school and my eldest son graduated some three years ago from Swansea medical school. So, that is now on record. Moving on, then, can I please welcome Dr Stephen Riley, dean of medical education, Cardiff University school of medicine, as well as Professor Ian Weeks, head of school, Cardiff University school of medicine, and Professor Keith Lloyd, dean and head of Swansea University medical school, who has appeared before this committee previously, but in a different role today in his role as dean in Swansea? I also welcome Craig Hathaway, who is a medical student at the Swansea University medical school. We have received your written submissions, so the questions will be based on what we've heard in the previous nine evidence sessions, as well as your written submissions. So, we'll go straight into questions then, if we may. You don't all have to answer every question, by the way, because we only have an hour. We're not going to be here all day. We'll begin with Dawn Bowden.

[3] **Dawn Bowden:** Thank you, Chair. Good morning, everyone, and nice to see you again. Can I just open up with a general question around the new single body, Health Education Wales, and what you think in particular the impact on that is likely to be, both in terms of the structure and the funding for medical education? Which one of you can kick off? Anyone—

[4] **Dr Riley:** I think it's an interesting proposal and follows similar funding models in the UK. I think trying to bring everything under one roof, one umbrella, is an important way to go. As you've heard in other evidence, trying to have a joined-up approach, an all-Wales approach, to the recruitment, retention and funding of healthcare is important. We're increasingly recognising that the inter-professional nature of healthcare delivery, and trying to co-ordinate that centrally, is something that I think is important. The difficulty, I guess, when it comes down to the funding, is healthcare is getting more expensive. It's getting more expensive to train individuals. We have to recognise that we have to train people locally and to try to balance all of those aspects is going to be a difficult job for that funding body, I think.

[5] **Professor Weeks:** Certainly, I think the inter-professional side of things is very important. I think it does give the opportunity to have much greater overlap between the disciplines and I think one can certainly applaud that, to improve efficiency and efficacy, for sure.

[6] **Professor Lloyd:** If I may, I think one of the criticisms you could level at the current arrangements is that there's something of a disconnect between training and service provision. By its nature, training is not the same as service provision, but if we're going to plan for the services we need in the future, we need to think, as my colleagues have said, multi-professionally, but also what the service needs are in particular areas. So, for example, if you have trouble providing doctors in west Wales, say, which is an example that's pertinent to us, then if you would move the training slots from there you perpetuate the problem and you make it worse, rather than realising the opportunities that the area might have, which is something that we might be able to realise through Health Education Wales.

[7] **Dawn Bowden:** Which is all to do with, presumably, the kind of forward workforce planning type of programme that they need to go through. How does that work now, then? Presumably, you identify the number of training places that you need and it either is approved or it's not. Do you see this new

body operating differently to that?

[8] **Professor Lloyd:** As medical schools, we're not primarily involved in the delivery in that aspect of the thing. It's the deanery that currently does that at the moment. I think there's a real opportunity for the universities to be more involved in that with the health boards, which is something that we're doing through ARCH, for example, and to actually be intimately involved in helping provide the solutions to the workforce needs of the future.

[9] **Dr Riley:** Wales is pretty much unique in the UK in having a single postgraduate deanery, you know, joined-up undergraduate education and a defined area. I think we can be world leading if we can get that structure right in terms of that delivery.

[10] **Dai Lloyd:** Can I just quickly ask Professor Lloyd to follow up on—. You mentioned the ARCH project. Maybe you could just tell us a little bit about that and whether that offers a model that others might follow.

[11] **Professor Lloyd:** Okay. ARCH stands for 'A Regional Collaboration for Health'. It's a collaboration between Abertawe Bro Morgannwg health board, Hywel Dda and Swansea University. It's got several strands to it and it's linked to the city deal bid as well, which has been in the news recently. The idea is that it will allow the university to work with the two health boards around improving the health and well-being of the population, driving economic growth and providing and promoting innovation and research. So, an example would be: the Cabinet Secretary for health was in Swansea this week and he was opening something called the Health and Wellbeing Academy in the school of human and health sciences, and that's about looking at providing a range of services in a much more social model of medicine, outside of general practice, allowing people to go and see an audiologist or a physiotherapist, or something like that, without having to enter the healthcare system. So, one of the things that we're working up at the moment is looking at improving primary and urgent care so that people don't end up in A&E. What this does is enable us to plan that on a regional level. To relate back to the previous question, in order to make that really work, we need to be thinking about the workforce that we need to deliver it, which is why we've started also training physician associates as well and advanced paramedics, because they'll be part of the workforce solution for that. So, that's essentially what ARCH does. It's potentially a model that could be very generalisable.

[12] **Dai Lloyd:** Oê, symud **Dai Lloyd:** Okay, moving on—Rhun. ymlaen—Rhun.

[13] **Rhun ap Iorwerth:** Bore da i chi **Rhun ap Iorwerth:** Good morning to i gyd. Siawns mai un o brif you all. Surely one of the main ddibenion, os nad prif ddiben, purposes, if not the main purpose, of addysg feddygol yng Nghymru ydy medical education in Wales is to darparu gweithlu ar gyfer yr NHS yng provide a workforce for the NHS in Nghymru. A oes yna beryg bod hynny Wales. Is there a danger that that has wedi cael ei esgeuluso? been neglected?

[14] **Angela Burns:** Sorry—

[15] **Rhun ap Iorwerth:** Do you have a problem?

[16] **Angela Burns:** Sorry, the translation has stopped.

[17] **Rhun ap Iorwerth:** We'll sort that out. I'll carry on while we sort that out.

[18] Surely one of the main purposes of medical education and training in Wales is to provide a workforce for the NHS in Wales. Is there, on reflection, a danger that that has somehow been neglected, driven perhaps by the nature of competitiveness within higher education?

[19] **Professor Lloyd:** I think both medical schools would say—I'm speaking for my colleagues here, but both medical schools would say that they're doing things to address that. For example, Craig here is on our rural and remote health track, which is aimed at providing—. Well, I'll let you speak.

[20] **Mr Hathaway:** It's an optional sort of course element where, for the course of the four years of the degree, you opt to attend lectures once a month or go and visit rural places where you get lectures from rural GPs, pre-hospital emergency medicine doctors, mountain rescue and things like that. It's to encourage people to experience working in rural areas. Another part of that is that you also get to go away on clinical placement around Wales much more than you would if you're not on the track. So, we make an actual decision to go away. I've been on placement in Ysbyty Gwynedd in Bangor, I've been to Aberystwyth twice—once in the hospital, once in a GP surgery—and with a GP in the Port Talbot valley as well. I liked Bangor so

much I'm going there next year as well. I've already planned that. The good thing about RRHIME is that, even though it's relatively new in the last few years, numbers have been increasing year on year. So, in the current intake there's about 15 or 16 students on that track, which accounts for just over 20 per cent of the year.

[21] **Rhun ap Iorwerth:** You're clearly the exact kind of medical student that we want. I'm sensing from you that you see a career working in medicine in Wales.

[22] **Mr Hathaway:** Yes, but I was living in England. I did my undergrad degree in England and I was living in Bristol for three and a half years. If I hadn't come back to do this medicine degree, I'd still be in Bristol. So, there's a positive.

[23] **Rhun ap Iorwerth:** We know from figures that we've seen that two thirds of medical graduates in Wales work in Wales afterwards. Do you think that's a good figure?

[24] **Professor Lloyd:** It could be higher.

[25] **Dr Riley:** I think what we're doing is striving for excellence. That proportion of graduates that stay in Wales has been relatively static over a few years. It drops further when you go further into training. When you get to higher postgraduate training, you get to about 46 per cent of the trainees who are graduates of a Welsh university. I think that there's been this perception that the number of Welsh-domiciled students has dropped, particularly in Cardiff. I've got figures here that show that's not the case. I've heard that 10 per cent of students are Welsh-domiciled in Cardiff. That's not right. There are 22 per cent to 25 per cent, depending on how you cut the figures, across the years. That's been relatively static as well.

[26] **Rhun ap Iorwerth:** As opposed to about 80 per cent in England and 50-something per cent in Scotland.

[27] **Dr Riley:** The funding model in Scotland is different. The funding model in Scotland allows that increase in Scottish numbers.

[28] **Rhun ap Iorwerth:** Okay, this is good. We're getting to a position where we're able to identify that there is another model in place that could help. Is it something that we should aim for? Because we have very, very

strong evidence. The RCP says:

[29] 'It is crucial that Wales makes a more concerted effort to attract its own students to medical school in Cardiff and Swansea.'

[30] Martin Jones of Betsi Cadwaladr says:

[31] 'if you're starting with a greater number of people who are predisposed to the idea of working within their local communities, then the likelihood of people coming forward'

[32] to study is higher. There seems to me to be a real drive towards trying to increase the number of Welsh-domiciled students in our medical schools. You are those medical schools. If it means looking to a different model in Scotland, so be it. What can be done to increase that number?

09:30

[33] **Professor Weeks:** I certainly think that when we look at our figures—and I'm sure Steve will confirm this—for this year, as against last year, I think we're up to 61 per cent, from 52 per cent last year, of applicants now who actually come into the school. So, we've got the right trajectory.

[34] **Rhun ap Iorwerth:** Fifty-one per cent of applicants—

[35] **Dr Riley:** Around 50 per cent of Welsh students will apply to Cardiff for an undergraduate place in medicine. For this year, it was 288 students out of about 570. Those figures have been relatively static over the last five years.

[36] **Rhun ap Iorwerth:** That's all Welsh students—sixth-formers making applications to study medicine anywhere.

[37] **Dr Riley:** Yes. This year, we've interviewed 213 of that 288. So, by contextualising the Welsh students and those students who are from underprivileged areas, we've managed to increase the ability to offer interviews to students. So, we're up to nearly 70 per cent of those who apply to us being interviewed. This year, we've been able to offer 130 places, of those 213. So, around 61 per cent of Welsh students who applied to Cardiff have been offered a place this year.

[38] **Rhun ap Iorwerth:** So, 83 of those students don't get into Cardiff. Do

you track those?

[39] **Dr Riley:** We haven't yet. So, there is a plan in place to try and do that. It's sometimes difficult to get those data. We do follow-up surveys with students, but not all students reply to us as to what's happened subsequently. We know that around 10 per cent of Welsh-domiciled students turn down our offer and go elsewhere, which is their own choice and we know that around 20 per cent of students don't achieve the grades to be able to get into med school, when it comes to A-level day. That's pretty consistent, whether you look at England, Scotland and Wales.

[40] So, those figures are starting to stack up. I'd absolutely agree with you that we need to get more Welsh-domiciled students in. If you look at the Scottish model and if you look at the models that I've visited in Washington state and in Maine, and I've talked to the people in Australia and northern Ontario, these models do allow a pipeline of doctors to come through into the NHS.

[41] **Dai Lloyd:** Julie first and then Angela.

[42] **Julie Morgan:** I had wanted to come in earlier on when Craig was speaking, but perhaps I could just continue on this theme for a moment because it's obviously very important. I just wanted to confirm on this: 61 per cent of Welsh students who applied to the medical school were interviewed, is it?

[43] **Dr Riley:** No; 71 to 72 per cent are interviewed and 61 per cent of the total who applied have got an offer.

[44] **Julie Morgan:** Have got an offer, right. That's fine.

[45] **Dr Riley:** So, 130 this year, which is significantly higher, compared to normally 80 to 85. So, we've increased that significantly this year, and that's through the use of the MMI—the multiple mini interview. So, fairness, openness and transparency and the use of contextualised approaches to being able to give the Welsh students that boost that they need, considering the schools and education system that we face in Wales.

[46] **Dai Lloyd:** Okay. Keith, from the Swansea perspective.

[47] **Angela Burns:** [*Inaudible.*]

[48] **Dai Lloyd:** Go on then, briefly, and then Keith.

[49] **Angela Burns:** Just very briefly, following Rhun's questions, because what you say sounds lovely, but on the ground, it doesn't transpire. Just two examples: I've got two students who didn't even get a look-in at Cardiff. They were told, 'Don't bother', and they're both now at Cambridge. They'll never come back to Wales and they're going to be bright, bright doctors. When they went to these roadshows that try to attract students, they were literally told by the people there, 'You're never going to get the grades' or—. I don't even know what the problem was because their grades predictions were absolutely top class—A*s all across the board—and now both of them are at Cambridge. So, now I've got angry parents, writing to me, saying, 'Don't Welsh universities want Welsh students? What's going on?'

[50] **Dr Riley:** The trouble is, without knowing the specifics—

[51] **Angela Burns:** I've written to your university on both of them.

[52] **Dr Riley:** Because that's certainly not the way that we operate now—

[53] **Angela Burns:** This is this year.

[54] **Dr Riley:** In which case I don't understand that. If they apply to us and they did have those grades, they would have been offered an interview. There's no doubt about it, because we were offering interviews for Welsh-domiciled students at lower grades than we did for everybody else because of this contextualised approach. So, I don't understand, and I'm more than happy to look at it with you and work out exactly why, because that's the sort of case we need to address.

[55] All I can say is that I want to take Welsh-domiciled students into the course, for all of the reasons I've articulated. I want to work with you to be able to achieve that with different funding models if we need to. We need to aspire to excellence, because that's what we want to have—an excellent health service. So, those are the messages that I would give, and I'd be more than happy to look at those.

[56] **Dai Lloyd:** Great. Well, perhaps a note to the committee to that effect would be good. Sorry, Keith—the floor is yours.

[57] **Professor Lloyd:** Thank you, Chair. I suppose the first point I'd make is that Swansea is a graduate-entry medical school, so it's slightly different. We have 1,000 applications a year of which we interview 300 for 72 places. If we had more places we could take more students.

[58] The second point I'd make is that contextual admission, as my colleague has described, is important, but there are other measures that can be taken, and we're describing something that we're calling a pipeline for encouraging people through, because the problem starts sooner. There will always be very bright Welsh students who don't get into medical schools, but there are a lot of Welsh students who don't actually fulfil their potential in schools, and we need to do a range of things to make it easier for them to get into medical schools subsequently. We have a number of feeder courses into our graduate-entry medicine course, and the proportion of Welsh-domiciled students on that is over 50 per cent. And we're introducing a system whereby people who get onto that course, if they do certain modules, will be guaranteed an interview for graduate-entry medicine. So, there's a range of initiatives that need to be focused on, not just at the point of entry, but the stuff that happens before.

[59] **Dai Lloyd:** Craig.

[60] **Mr Hathaway:** I just wanted to say that, all the time, especially now Swansea has shot up the UK medicine school league tables to No. 6, it's only going to get more appeal to the outside—the English domiciled and elsewhere in the EU, at the moment. So, it's really important that we do get an increase in these Welsh-domiciled students because there are only going to be more people from outside as the uni gains appeal. I've helped with this Reaching Wider programme; we had some Welsh-medium schools come to the university, and we were trying to encourage not only medicine, but also allied health professions as degrees. Really, it could be a bit altruistic, that, because hopefully, I suppose, they would apply for medicine and get in, but also, if they didn't, as a backup, they could take a route that so many of us do now, through the graduate-entry course.

[61] **Dai Lloyd:** Good. If we move on to Caroline—your questions are on applications and admissions, and Angela can come back in on the back of those. So, Caroline—

[62] **Caroline Jones:** Yes, diolch, Chair.

[63] **Dai Lloyd:** —some issues have already been covered, so there's no need to go over old ground.

[64] **Caroline Jones:** Yes. I was just wondering, can you tell me what the key factors are in determining which applicants get interviewed and admitted? Are the academic factors—do they play a key role in determining this, or non-academic elements? What's the proportion? How do you apportion the non-academic and the academic and take everything into consideration regarding an application?

[65] **Professor Lloyd:** For graduate-entry medicine, applicants have to undergo a test called GAMSAT, which is Australian in origin. Most UK medical schools use such a test. We use one called GAMSAT. And that's used as part of the interview selection process because demand so outstrips supply at the moment. There are 1,000 applicants for 72 places, so we have to do something.

[66] Then, people apply in the usual way and they write a personal statement, they fill out a CV, a standard form, and we sift all of those, and then we interview about 300, and they have a series of interviews. I think Craig is going back to help with that process this morning. So, we have student ambassadors taking part in that to make people feel at ease. Then we have a moderation exercise after that where everybody sits down and works out what is the best way of dividing up the small number of places. We're looking for the people who we think will make the best doctors. So, in most medical schools, academic criteria—previous exam results count for a lot. What we're trying to do with the process we're introducing through our feeder courses is to recognise that people will come to our courses without, necessarily, the right level of academic qualifications. So, Craig, for example, was telling me yesterday about his route into medicine, which is a very good illustration of that.

[67] **Caroline Jones:** Okay. And the collation of data regarding these applicants—you said that it hasn't been exactly good in that context.

[68] **Professor Lloyd:** My colleague said that. [*Laughter.*]

[69] **Dr Riley:** Follow-up data are difficult to get, by their very nature. So, we're slightly different. We have 3,000 applicants for 268 places, so an order of magnitude higher. We operate a multiple hurdle model that allows us to sift through. We know that previous academic performance does predict

ability to get through a course, and we don't want to set students up to fail. So, what we do is we use academic achievement at GCSE, accepting the Welsh system, giving that leg up to get over into an interview, then we assess the non-academic skillsets that we require to make good doctors within the multiple mini interview and take those two things together to then offer the place. Now, many medical schools in the UK will use something similar to GAMSAT called UKCAT. We don't use that, because we know that that would disadvantage our Wales population, so we positively ensure that we give Welsh-domiciled students the best possible chance to get in.

[70] **Dai Lloyd:** Rhun next, then Julie.

[71] **Rhun ap Iorwerth:** Making a point, more than anything: again, it revolves around this business of giving Welsh-domiciled students the best chance, Chair, when I'm told about the student who was one grade too short on English at GCSE to be offered an interview, but had that grade in Welsh, but it was deemed that that wasn't good enough.

[72] **Dr Riley:** That comes back to, I guess, the written senate regulations of a particular course. Now, it may be that we have to look at those senate regulations and say, 'Hold on a minute, should we be doing that exact approach?' So, it's about the minimum requirements that the university set and, therefore, can you influence that, can you change that? I would argue that we should look at it and try and change it.

[73] **Rhun ap Iorwerth:** It's about the Welsh context—the rules by which you're governed and—

[74] **Dr Riley:** Absolutely, yes. And I think we, perhaps, have lost sight of that, but we are, with the changes that we've made to C21, the focus on excellence, the focus on patient centredness, the focus on community-based learning—then all of that can come back into play.

[75] **Dai Lloyd:** Craig, you had a point.

[76] **Mr Hathaway:** Yes, the point I was just going to make is to enter into graduate medicine at Swansea University—it is based on degree. So, even though I didn't apply for medicine, I chose to do pharmacy before—I probably wouldn't have got into medicine the first time around. But there are a lot of people who didn't choose science qualifications before A-levels et cetera, and the beauty of the graduate medicine course in Swansea is that we

accept students who, maybe, at 18 didn't know their career path and didn't choose the right one.

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

[78] **Julie Morgan:** You want me to go back now.

[79] **Dai Lloyd:** Yes. No. [*Laughter.*] It's all the same situation, we never go back, we always go forward, Julie. The floor's yours.

[80] **Julie Morgan:** I had wanted to ask about what you said about the rural placements and all that sort of thing, when you raised that, which I thought was very interesting and very encouraging, really. But you did say it was extra to the curriculum and then you said that some of the placements ended up being of that nature, so I just really wanted to understand that a bit more.

[81] **Mr Hathaway:** The evening talks that we get are optional, but anyone who signs up to this theme throughout the four years is expected to go to those.

[82] **Julie Morgan:** That's actually part of the course, then.

[83] **Mr Hathaway:** Yes, it's part of the course, and you get a formal recognition of you taking part in RRHIME at the end of the degree as well.

[84] **Julie Morgan:** Right, thank you. I only wanted to clear that up, because it's very positive, I thought.

[85] **Dai Lloyd:** Excellent. Angela, did you want to come back in here?

[86] **Angela Burns:** Yes, I just wanted to ask—

[87] **Dai Lloyd:** On this issue?

[88] **Angela Burns:** No, I want to ask about undergraduate training.

[89] **Dai Lloyd:** You can, indeed.

[90] **Angela Burns:** If I may.

[91] **Dai Lloyd:** It's still—[*Inaudible.*]

[92] **Angela Burns:** I don't know the details of what is contained within undergraduate training, and I wondered if you could let me know if there is enough exposure, in your view, to general practice.

09:45

[93] **Dr Riley:** If you look at all of the different courses in the UK, they all have different exposure to general practice. There's a publication recently by Val Wass, which looks at what you need to put in place to develop a focus on general practice, if you like. It's clear that it's not quantity; it seems to be quality that's important.

[94] So, taking on board those recommendations and looking at the way in which we're talking now, within C21, about trying to focus on community-based learning and this idea of trying to embed students within the community and in smaller groups, developing this symbiotic relationship with the NHS to train these individuals locally, so that the model that we're looking at now is this idea of a longitudinal integrated clerkship, where we embed students within general practices and try and teach medicine within those practices in a patient-centred way in the rural parts of Wales, which should address some of those issues.

[95] I think we've become much more product focused in our approach to medical education, so this idea of, 'What is it we're trying to deliver to the NHS?' And that is this idea that we have specialties that are short: psychiatry is another example, so, we're trying to address that by specifically addressing psychiatric issues within the curriculum, and some evidence is saying, from what we've done here, that those students are becoming more attuned to potential careers in psychiatry and general practice.

[96] Cardiff has always been mid-to-high table in terms of the number of its graduates that end up being GPs. That dropped down to about 20 to 22 per cent on the last figures that we've seen from the General Medical Council. But so have many other of the schools in the UK. So, it's about trying to adopt best practice and training people within the community in a patient-focused way.

[97] **Professor Lloyd:** The answer to your question is that probably not enough go into general practice. Our figures for people who've done the four years at Swansea show that 30 per cent go into general practice, which is

high on the UK basis. We also have one of the highest proportions of people going into psychiatry, as it happens, in the UK.

[98] **Dai Lloyd:** Including yourself.

[99] **Professor Lloyd:** Yes, but they still go into psychiatry, despite me being the dean, yes. [*Laughter.*] There's a second issue that is about the need for people who work in hospital specialties to recognise and value the importance of community specialties, and that's going to become increasingly important. As we have different models of care, as we move away from hospital care towards more community and intermediate and ambulatory care and a more social model of medicine, that's going to become increasingly important. So, we are going to need more people in those kinds of roles, yes.

[100] **Angela Burns:** So, could you clarify something for me? If you decide that you want to be a GP and you have to go through all the training at university, do you still do those rotations in hospital?

[101] **Professor Lloyd:** Yes, you do.

[102] **Angela Burns:** And is that under your purview, or is that what the royal colleges say?

[103] **Professor Lloyd:** No, neither; it's the deanery. There are two points in what you said. The first is that we were thinking of introducing a primary-care track, right from the beginning of our course. The problem is that, very often, when people come into medical school, they don't know what sort of doctor they want to be at the end. One of the wonderful things about medicine is that there are so many different trajectories you can go on in it. We can end up doing all sorts of different things. So, you actually have to allow people a certain amount of flexibility, because they may have an epiphany later on in their course and decide what it is they want to do. You're choosing between, I think, emergency medicine, anaesthetics or general practice—

[104] **Mr Hathaway:** Yes, sort of acute medicine or GP, I don't know.

[105] **Professor Lloyd:** He doesn't know yet.

[106] **Mr Hathaway:** With regard to GP teaching on the Swansea curriculum,

we go into GP practices, I think it's from the second or third week of university in the first year. In the first and second years, it's every two to three weeks, and then we do block placements in years three and four. So far, I've been to Glyncoed, Port Talbot valley, a Swansea city GP, a placement in Aberystwyth and next year, I'm either doing St David's or Brecon. So, they can be all over Wales. Some of my colleagues have been up to north Wales, as well. So, it gives us an experience of a city GP practice and a rural GP practice.

[107] **Angela Burns:** So, sorry to beat this point to death, but I just want to make sure I clearly understand it. When you are doing your undergraduate medical training, do you have to, as part of the course, do a placement with a GP?

[108] **Professor Lloyd:** Lots of placements with GPs.

[109] **Angela Burns:** You do. And, the rotations in hospital, who decides those?

[110] **Professor Lloyd:** The foundation placements that happen after qualification are specified by the GMC and by deanery.

[111] **Angela Burns:** Right. And some of those rotations are compulsory, but not all of them. So, do you have to do, for example, orthopaedics?

[112] **Professor Lloyd:** No.

[113] **Dr Riley:** No.

[114] **Angela Burns:** Oh right, so they can just choose what they want to do.

[115] **Professor Lloyd:** Yes.

[116] **Dr Riley:** Yes.

[117] **Dai Lloyd:** But if you're on a GP training scheme, you end up doing a year of general practice and then six months of obstetrics, six months of paediatrics, six months psychiatry, like it did.

[118] **Angela Burns:** And so, if you're doing your year of GP training, who monitors the quality of that training? Because, one of the complaints that I've

heard from trainee GPs is, actually, they then get dumped into a GP situation and it's horrendous, and then they leave general practice. We're trying to drive more people to have an interest in that particular branch of medicine.

[119] **Dr Riley:** Wales Deanery.

[120] **Angela Burns:** Wales Deanery, thank you.

[121] **Dr Riley:** And they do a good job of that, I think.

[122] **Dai Lloyd:** Okay. Time is—it's all very interesting stuff, obviously, but time is marching on. Lee, some of your issues have been covered, but you can drill down about Scotland if you like. Or anything else, feel free—

[123] **Lee Waters:** Thank you very much.

[124] **Dai Lloyd:** But make it medical.

[125] **Lee Waters:** Indeed, I will. I'm interested in the—. Clearly there's a consensus building from our side that you are doing better than you were, and we would like to see you do better still. I'm just interested in the counter pressures that you might be under. Is there a resistance internally from some academics who fear that having more Welsh-domiciled students may impact on your broader reputation, may dilute standards? What are the counter pressures that you face within the institutions against going in this direction?

[126] **Professor Weeks:** I think, speaking from a Cardiff perspective, and I'm sure Swansea would say the same, there's absolutely no reason why shouldn't want to encourage Welsh-domiciled students, it's counterintuitive. As Steve said earlier, what it's about at the end of the day is creating quality doctors, and giving Welsh-domiciled students as much opportunity as we can to maintain that quality and really drive up as many Welsh-domiciled students coming through the system as we possibly can. From our perspective, there is no rationale for doing anything else.

[127] **Lee Waters:** Okay.

[128] **Professor Lloyd:** I would agree with what's been said, and add that we want to facilitate all underrepresented groups to have better access to medical degrees, and Welsh-domiciled students can be one of those groups. There can be separate issues there, but there's an overlapping set of issues

there. So, we have the issue of Welsh-domiciled students, our ambition is to be a medical school for Wales with global reach, so we're trying to do that, but there are other groups that we need to consider who are underrepresented for other reasons.

[129] **Lee Waters:** I'm just trying to tease out whether there's any sort of cultural drag, if you like. I was struck by the evidence of HEFCW in their submission, which says that,

[130] 'Admissions to autonomous universities need to be transparent, and cannot favour Welsh-domiciled students and this needs to be taken into account in planning.'

[131] So, there's clearly some mindset or some cultural resistance from a HEFCW point of view, so I'm just wondering where that's coming from and how that reflects itself in your institutions.

[132] **Professor Weeks:** In a sense, irrespective of wherever that's coming from, as Cardiff University we have a commitment to Wales. I'm Cardiff born and bred and I wear that on my sleeve, so—

[133] **Lee Waters:** I'm not asking you to get your flags out I'm just, you know—. To properly progress this agenda, we need to understand the full context that you're working within, and whether there are some issues that need addressing broader than your willingness.

[134] **Professor Weeks:** Yes. I'm not aware of that.

[135] **Dr Riley:** I don't perceive that there is any block to promoting Welsh-domiciled students into the course. I'm fully in favour of that, we're fully in favour of that. I think the fairness, openness and transparency of the application process is something that we hold very dear, and what we don't want to risk is a big press story, for instance, that, 'Your process has a bias towards x' without having the legislative backing to say, 'This is the way you need to go.' Within the rules of the game at the moment, we are doing all that we possibly can within the contextualised approach to get the Welsh students in. If we can raise the number of Welsh students that apply to us from 50 per cent to 75 per cent of those students, then clearly that's going to increase again, because we will have more students to choose from. So, I think that's what we're coming back to. We can talk about the Scottish model if you wish.

[136] **Dai Lloyd:** Not yet. Ian, then Keith.

[137] **Professor Weeks:** I think one of the things that I would say is that we're talking very much about the admissions process, and I think you've heard what Swansea and Cardiff are doing to maximise the opportunities for, certainly, Welsh-domiciled students, which is what Rhun is very much coming from here. But I think it's really about taking that step further back and creating motivation, I think, for schoolchildren. I'm sure Swansea will do the same, but we have a very active programme of engaging with primary school children, for example, to talk about STEM subjects generally and medicine in particular, obviously. I think one of the big success stories that we've certainly had going on to secondary education over the years is that we have an event called Science in Health Live every year. We have coachloads of secondary school children coming in. This has been so popular that we've had to spread it over two days because the sheer number of schoolchildren becoming involved in that is so high. So, I think initiatives like that will help motivate the children of that age to come into STEM subjects, and medicine on the back of that.

[138] **Dai Lloyd:** Great. Keith.

[139] **Professor Lloyd:** Okay. I haven't seen the particular piece of evidence from HEFCW that you referred to, so I can't comment on that directly. What I would say is that the Medical Schools Council, which is a representative body of the UK medical schools, publishes each year a set of criteria for admission to each medical school. The vast majority of medical schools use contextual admission.

[140] **Lee Waters:** Can you I just pick on something that Professor Riley said, because you alluded to an alternative funding mechanism? You also alluded to the limits of the statutory framework that you work within. So, in terms of recommendations that this committee might make, are there things that the Welsh Government could do differently on a structural level that would help advance this agenda?

[141] **Dr Riley:** I think the way that the funding model works at the moment: for instance, in Scotland they fund a set number of places, which allows Scottish students to be drawn into Scottish universities rather than applying preferentially to other universities in the UK. So, changing that funding model would be one way in which you could influence the way in which you

could legitimately take more students into the Cardiff course. I would say that there needs to be a balance. I'm proud to be a graduate of Cardiff University. I'm from Birmingham originally. I didn't get into Birmingham. I applied to Birmingham. Wales gave me a place. I've never left. I hope that I've contributed back to the economy of Wales. So, there has to be this—. We have to drive more Welsh-domiciled students in, for certain, but we have to also say that there are people that could potentially come into Wales—as Keith, I think, has alluded to as well—that will contribute positively to our health service and our economy.

[142] **Dai Lloyd:** Okay. Rhun, you're agitating to say something.

[143] **Rhun ap Iorwerth:** Again, it was making a point. It's not about saying that we don't want great medical students from outside Wales to come here. It's the double, the triple or the quadruple lock, isn't it? We're very fortunate that you came to study in Wales and that you have not just made a contribution economically, but to the health of the nation and so on. But if we can lock people in and get people in who are from Wales and are therefore more likely to want to stay in Wales, study in Wales and therefore be more likely to stay in Wales. We had Betsi Cadwaladr even saying that we should increase, specifically, Welsh speakers in order to serve the NHS in Welsh-speaking parts of Wales. It's looking for those locks, isn't it, and the role that medical schools in Wales can play in promoting that? You talked about contextual admission. We need a Welsh element of that context as well, and that is what we need to be looking at, I think. There's a different context to those other medical schools in England that are part of the same admissions policy. We have different needs.

[144] **Dr Riley:** Our contextual approach is different to England, and it is Welsh focused.

[145] **Dai Lloyd:** Craig, and then Ian.

[146] **Mr Hathaway:** Just quickly on your point about Welsh speaking, there are a lot of English students who have come onto the course. Some of them are Welsh domiciled, but they happen to have been born in England. The course itself runs free Welsh lessons. It's only basic Welsh, but that's a big advantage for patients who want to—. You know, just as has been said, 'Hello' or 'Thank you' in Welsh is really good for them. But the point that I put my hand up for was about funding and incentives for bringing students into Wales, to study in Wales and to stay in Wales. I couldn't have applied to

Cardiff. I could have physically applied to Cardiff as a postgraduate student, but I wouldn't have received the same amount of funding as I would have with the postgraduate GEM courses. With regard to Wales compared to the rest of the UK, the funding is largely similar, apart from Scotland.

10:00

[147] With regard to keeping people in after, it may be worth—I don't know how feasible that is—exploring options of being different from England. I know the junior doctor contract will help a little bit, but the fact that if Wales was different with regard to, I don't know, incentives for staying in Wales, then definitely a lot of my colleagues would stay in Wales.

[148] **Dai Lloyd:** Okay. Ian, on this point.

[149] **Professor Weeks:** I think it's important on so many levels. We've talked about the undergraduate level, the postgraduate entry. We've talked about how much impact we have to make with schoolchildren as well. And the other point is about the postgraduate education as well. This point, I think, that we're looking at about creating education in rural communities as a key part of the course—certainly Cardiff's initiative to try and do that—and we're putting that plan together at the moment. I think it's very much about being innovative in what we do in Wales. We are a very innovative nation and I think this is an area where we should be innovative. We shouldn't follow the existing English system. I think we have an opportunity to create something that will suit us as one of the devolved nations, rather like Scotland has been doing. So, I think it's extremely valuable to have this kind of exercise.

[150] **Dai Lloyd:** The number of questions left roughly equates to the number of minutes left in this session, so I would appeal, mostly on this side, I have to say, for succinct contributions. Keith.

[151] **Professor Lloyd:** I was simply going to say that there's lots more we can do and we can't be complacent about retention. Our latest figures are that 67 per cent of people who've trained in Swansea have stayed in Wales after qualification. So, we're on track; we just need to do more of it.

[152] **Dai Lloyd:** Great. Caroline, moving on.

[153] **Caroline Jones:** Diolch, Chair. What kind of destination data is there available for Welsh medical school graduates to help us understand more

about doctors' choices in training?

[154] **Professor Lloyd:** If I may, you've had evidence already from one of my colleagues, Dr Heidi Phillips, who is admissions tutor in Swansea. She's done a project where she's looked at the trajectories of all our students. We know that people who graduate from us are more likely to go into general practice than—. They're more likely to remain in Wales. They're more likely to go into general practice than other shortage specialties. We don't have that many years of data yet, so it's still working its way through the system. But, there's good evidence emerging that people, particularly from graduate-entry medicine, tend to stay in the areas where they train and work, and put down roots if they don't have them there already.

[155] **Caroline Jones:** That's interesting. That's good.

[156] **Mr Hathaway:** Just really quickly, I've bought a house, but, initially, I wasn't planning to definitely stay in Wales, but now I am. Also, with regard to postgraduate medicine, it's four years, so you get from student to doctor much quicker than undergrads.

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

[158] **Dai Lloyd:** Moving on. Julie, some of your issues have been addressed, but feel free to address some more.

[159] **Julie Morgan:** Yes, I wanted to ask about how you were reaching deprived communities really. Obviously, we've had some general comments already. Is there anything you could add about those particular efforts where people have never thought to aspire to be a medic in any way? Anything to add on what you've said already?

[160] **Dr Riley:** We've got some specific examples. So, with Tredegarville primary school, our medical students go up and speak to the schoolchildren. They've also been back down to Cardiff to have a little look around the clinical skills lab. Our students are allowed to special study components—SSCs—and we have a number of our students now who are looking at ways in which you can reach out into communities to increase the aspiration of the schoolchildren. And we've got the links with the Seren hubs that are starting to form now. So there's a Seren conference next week; we're going there to try and talk to the A-level students, again to give them information about the application process and inspire them to apply to Wales to study medicine.

[161] **Julie Morgan:** Would you say that students as they are at the moment generally come from reasonably well-off backgrounds?

[162] **Dr Riley:** I think there's a real mix.

[163] **Julie Morgan:** There is a mix, you think.

[164] **Dr Riley:** There is very much a mix, and we've got students who are first-generation medic applications, and we've got students who are from a medical background. There is a real mix between the two.

[165] **Dai Lloyd:** Craig.

[166] **Mr Hathaway:** I was the first person in my family to go to university. I came from a village that you could class as relatively deprived, and, with regard to ongoing work in these areas that are deprived around Swansea, the admissions director, Heidi Phillips, is doing work with some schools that, in the last 10, 20 years have never churned out a doctor at all. So, she's focusing on those schools as a priority to try and encourage uptake of medicine and allied health professions.

[167] **Julie Morgan:** So, you've all got this firmly on your agenda.

[168] **Dai Lloyd:** Moving on to question 10—Lynne, we're talking numbers of training places.

[169] **Lynne Neagle:** Yes. We've had some evidence that people would like to see more training places available in Wales. What is your view specifically on that and whether we need a new training facility in Wales?

[170] **Professor Lloyd:** We have submitted other evidence suggesting that we could expand our offering into west Wales, and, working closely with Hywel Dda, they're keen to take more of our students. Many of the issues that apply to healthcare in west Wales also apply in the north. Both of our medical schools have been in discussion with Welsh Government about expanding, as you know, and contributing to any expansion of the offering up there. I think we're all keen to do that. England have just announced 1,000 extra places for training medical students. Welsh students will take up those places. Worcester, Chester—a number of universities on our doorstep are looking at increasing their offering. If we don't up our game, those students will go to

England and may not come back.

[171] **Lynne Neagle:** Okay. So, you think it's more about working in partnership then, rather than looking at developing something new. Okay.

[172] **Dai Lloyd:** Okay. Rhun.

[173] **Rhun ap Iorwerth:** Specifically on the development of medical education in the north-west of Wales, I'm talking here about people applying to study medicine in Bangor, not just doing placements in Bangor, which, of course, they currently do anyway. Do you think that there is support for moving in that direction—even possibly, medium term, a medical school in Bangor, but that's probably parked for the time being—and having medical education based in Bangor as a means of addressing specifically, perhaps, the rural medicine shortages that we have?

[174] **Professor Lloyd:** We think that, for example, the rural and remote health track that we offer would be ideal and have had discussions, as have my colleagues in Cardiff, with north Wales about offering more placements there in the short term, given the long lead time to actually starting a medical school.

[175] **Dr Riley:** I'd agree with that. I think we can work towards that with you. I've been in contact with the Northern Ontario School of Medicine, which has got a specific francophone programme that allows students to go into those communities that are predominantly French speaking to do their programmes. You have to get the—I think as Dean Williams said to you, it's about the science faculty that needs to be there. Yes, we can deliver very high-quality clinical placements up there; it's the science faculty and all the stuff that goes around developing a well-rounded medical student that you need to have in place, and that's a programme.

[176] **Rhun ap Iorwerth:** And there's no reason practically, even though the medical school takes, you know, there's a long run-in, but there's no reason why people shouldn't be able to apply to Bangor to study medicine, perhaps because of a relationship between Bangor University and Cardiff University, within a relatively short space of time.

[177] **Dr Riley:** We'd have to work through that with you.

[178] **Dai Lloyd:** Okay. Julie has got some issues about Europe.

[179] **Julie Morgan:** Yes, Brexit. I mean, it's obviously something that's on everybody's minds at the moment, and I understand there has been a fall in the number of EU applicants to medical schools. So, perhaps you could give us your views on how this is going to develop.

[180] **Professor Lloyd:** The issue, I think, is more for the NHS workforce than it is for medical school applications. We don't take many EU residents—non-UK EU residents—onto our course. I think where Brexit will have an impact is downstream of that in terms of the workforce that you have after qualification, would be my take on that. And also, a particular local point, Michael Heseltine was supposed to come and visit us yesterday in Swansea and he appears to have got embroiled in some local difficulties.

[181] **Dai Lloyd:** Sad. Ian.

[182] **Professor Weeks:** I think the other thing to consider that's very important in that, because, of course, the other side of the medical school—talking about creating good doctors, excellent doctors for the future—is about the research side of things as well, because that does attract a lot of people to an area. I think Brexit is clearly going to impact on the research side of things and our ability to attract quality research, and this is causing a lot of issues for us at the moment. I think the combination of the service, the combination of whether ex-UK students want to come and train in the UK and Wales particularly, and the research—we talk about the triple lock; I think this is a bit of a triple whammy, which is potentially problematic for us.

[183] **Julie Morgan:** In terms of undergraduates from the EU, do you have many? Do you know the numbers?

[184] **Professor Weeks:** I don't know the numbers. Would you be able to answer?

[185] **Dr Riley:** We didn't have many at all until we started to change our curriculum. Paradoxically, those numbers have increased year on year over the last three or four years. We haven't seen that drop-off yet, although the numbers are down in the UK as a whole.

[186] **Professor Weeks:** Just to point out on that, in terms of again going back to the research, as Cardiff, we're fifth in the UK in terms of research and second in terms of research impact. I think we worry about how difficult it's

going to be to hang on to that.

[187] **Julie Morgan:** Has there been any actual evidence yet? Sorry, Craig, I know you want to come in.

[188] **Professor Weeks:** Certainly, colleagues in the research environment who are currently EU citizens have expressed the view that they're looking to move back out of Cardiff and back to their homelands.

[189] **Julie Morgan:** Yes, I've heard that anecdotally, but is that actually happening?

[190] **Professor Weeks:** People have told me—my colleagues have told me this—that this is something that they're considering.

[191] **Dai Lloyd:** Okay, Craig.

[192] **Mr Hathaway:** To my knowledge, we've got two EU students in my year of 72. I obviously wouldn't know what would happen if Brexit went ahead, and it depends on the outcome. But both of those individuals—one was a feeder course via Swansea University, so that person stayed in Wales and has chosen to study in Wales, and the other person had been working in the NHS for a number of years before and then decided to change career. So, even though they are EU students, they've actually been in the UK for some time. I think that's good as well, because we want to create doctors that will work in the UK. By showing that these people have been living in the UK before, that's got to be positive.

[193] **Professor Weeks:** I think the other thing that's important is the whole student satisfaction thing, certainly in terms of making Wales a place where students want to come. So, we've been working hard to drive up our national student satisfaction scores. We've achieved 97 per cent in medicine this year, which we're very proud of. Again, the worry is trying to maintain that position with all that's going on around. It really is a very worrying time.

[194] **Julie Morgan:** So, Brexit, you could say, has really increased your anxieties for the future?

[195] **Professor Weeks:** It has, yes. And we're currently joint third in the UK in terms of student satisfaction—I think that's something to be proud of and something that we'd quite like to hang on to—of all the other UK medical

schools.

[196] **Dai Lloyd:** Okay, time's marching on and Angela has got the last question, for which you've got 13 microseconds to use up asking it.

[197] **Angela Burns:** I was reading the minutes of a patient participation meeting not very long ago, and in the minutes was a comment that said that Swansea University's medical school was considering looking at or evaluating—I can't remember the exact wording; I don't have it with me, I'm afraid, but I'm happy to provide it to you—a Welsh qualification or a Welsh necessity to the application process. Is that correct? And also, if—. Well, is that correct?

[198] **Professor Lloyd:** I'm not sure I fully understand the question.

[199] **Angela Burns:** The minutes said, and it was from a doctor, that Swansea University was looking at making Welsh a pre-requisite qualification for entry. I'm not sure—

[200] **Professor Lloyd:** Okay. No, we're not looking at making Welsh a pre-requisite. We have increased the opportunities for people to spend as much of the course as they wish to do through the medium of Welsh, and you can do a number of clinical placements in Welsh, but we're not looking to make it an entry requirement—that I'm aware of.

[201] **Angela Burns:** Okay. I assume—this is for both of you. I think one of you—I think it might have been you, Stephen—said earlier that you had to make sure that whatever you do with your entry requirements was legally—that you weren't going to be under fire legally. I assume that setting your entry requirements is entirely down to you. Therefore, if you were to set an entry requirement that said it is preferable for a student to have studied the Welsh baccalaureate, would that not help to predispose the amount of Welsh students coming into the university and being accepted?

[202] **Dr Riley:** I think it might have been that it was Cardiff who was thinking about doing this exact thing. There is a possibility, and we're exploring it now with our quality standards committee, of having a separate route of entry that would require—. It might be a medicine degree with Welsh culture alongside it and, to get into that degree, you might, for instance, need a Welsh language qualification or a Welsh bac.

10:15

[203] So, it's a mechanism that's aligned with what's happening in Scotland, but a slightly different focus to advantage that approach. It's complex, because you're having to think about what's the content of the course and how you reflect that when you accredit the course at the end of it, both from a GMC professional practice perspective and from a university standards perspective. So, we are actively looking at it, but I can't tell you whether that's going to be something that we can—. We can drive it forward, but whether it will come to fruition is something that we need to work on in the next few months.

[204] **Angela Burns:** So, you couldn't just say, 'You've got to have English, Maths and Welsh bac, for example, in GCSE, as a preferable. You have to then prove an outcome, do you, for that request.

[205] **Dr Riley:** We'd have to go through the quality and standards committee to be able to do that. But it's on the cards.

[206] **Dai Lloyd:** Okay. Diolch yn fawr iawn. That is the end of the session. Thank you very much indeed. A very high standard of evidence this morning.

[207] Diolch yn fawr iawn i chi i gyd. Thank you very much to you all. Can I A gaf fi bellach ddweud y byddwch yn just let you know that you will receive derbyn trawsgrifiad o'r cyfarfod yma a transcript of this meeting and the a'r trafodaethau i wneud yn siŵr bod discussions we've had so that you popeth yn wir ac rydych wedi cytuno can check that everything's correct efo beth yr oeddech wedi ei ddweud? and that you agree with what has Gyda hynny, dyna ddiwedd y sesiwn. been noted? That's the end of the Bydd yna egwyl rŵan am chwarter session. There will be a break now awr, achos mae popeth wedi'i amseru for 15 minutes, because everything is i'r funud, fel sydd yn berthnasol i timed to the minute here, as is feddygaeth—popeth i'r eiliad. Felly, relevant to medicine—everything to diolch yn fawr i chi am eich the second. So, thank you for your presenoldeb ac fe welwn ni chi eto, attendance and I'm sure that we'll siŵr o fod. see you again.

[208] I'm cyd-Aelodau, mae yna To my fellow Members, there is now doriad nawr tan 10:30. Diolch yn a break until 10:30. Thank you. fawr.

*Gohiriwyd y cyfarfod rhwng 10:16 a 10:31.
The meeting adjourned between 10:16 and 10:31.*

**Ymchwiliad i Strategaeth Genedlaethol Ddrafft Llywodraeth Cymru ar
Dementia—Sesiwn Dystiolaeth 7—Pobl sy'n Byw â Dementia
Inquiry into the Welsh Government's Draft National Dementia
Strategy—Evidence Session 7—People Living with Dementia**

[209] **Dai Lloyd:** Croeso nôl, felly, i ail sesiwn dystiolaeth y bore o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. Hwn yw eitem 3 y bore yma. Croeso nôl i'm cyd-Aelodau. Eitem 3 yw'r ymchwiliad i strategaeth genedlaethol ddrafft Llywodraeth Cymru ar ddementia. Hon ydy'r sesiwn dystiolaeth olaf o'n hymchwiliad ni. Bore yma, rydym yn mynd i glywed tystiolaeth gan bobl sydd yn byw gyda dementia. Felly, rwy'n croesawu Nigel Hullah, Karen Kitch, Madeline Cook, Beti George, Michelle Fowler, sydd yma gyda chyfieithydd, ac Emily Jones. Croeso i chi i gyd. Mae gennym gwestiynau.

Dai Lloyd: Welcome back therefore to the second evidence session of the morning of the Health, Social Care and Sport Committee here at the Assembly. This is item 3 on our agenda. Welcome back to my fellow Members. Item 3 is the inquiry into the Welsh Government's draft national dementia strategy. This is the final evidence session in our inquiry. This morning, we're going to hear evidence from people who are living with dementia. So, I welcome Nigel Hullah, Karen Kitch, Madeline Cook, Beti George, Michelle Fowler, who is here with an interpreter, and Emily Jones. Welcome to you all. We have some questions.

[210] We have questions based on the evidence in all the evidence sessions thus far, which will give you sufficient opportunity to, hopefully, outline all that needs to be said from your point of view. Okay? If somebody has opening remarks, we shall welcome those now. Anybody want to go first? Nigel, go on. Crack on. That's what we want—a willing volunteer.

[211] **Mr Hullah:** I'll go first. My name is Nigel Hullah. I'm on the Welsh strategy task and finish group. I'm also a member of the cross-party group, and I think I've met with a couple of the AMs outside of the strategy. Can I first thank you for giving us the opportunity to give evidence to this group? And can I also say that I was in a meeting yesterday in London with the UK dementia think tank, of which I'm a member? The general feeling amongst the rest of the UK is that they're looking at Wales, scratching their head and

wondering what we're doing and how well we're doing it. There's a great deal of interest in the way the strategy has been put together, with, I think, a commitment to the involvement of people living with dementia. But saying that, Mr Chairman, there's a long way to go just yet. When the questions come up, I think we will all be in a better position to answer that.

[212] **Dai Lloyd:** Great; thank you for that. We're well aware of the present situation, and we're also well aware of the long way that we need to go. Caroline Jones has got the first question.

[213] **Caroline Jones:** Diolch, Chair. Good morning, everyone. Could you tell me please what experiences you've had when you've gone to see, for example, your GP and primary care services? Are they dementia friendly? And how we can improve upon the services that are available, and that can better meet the needs of people with dementia and, of course, their families and carers.

[214] **Dai Lloyd:** Who wants to kick off? Then you can all pitch in? Michelle.

[215] **Ms Fowler:** Good morning, everyone. Thank you for inviting me. It's the first time I've been involved in anything like this. I'm representing the deaf community. I work for the British Deaf Association, and we represent people whose first language is British Sign Language.

[216] The first thing I'd like to say is that there is absolutely no provision for deaf people with dementia in Wales. The diagnosis is very difficult because there are no specialists, and we would need to be diagnosed in a different way. The memory tests are not suitable; they're not appropriate for deaf people. For example, if you asked them maybe who the Prime Minister was a few years ago, they would struggle to know the name, because they've had such a poor education that they struggle with their literacy skills, so they don't read very well. Most of them left school with a reading age of 8, so just basic news and general knowledge they would really struggle with, and in a memory test they might never have known that information, so it's not that they've forgotten it.

[217] So, really, at the moment, the provision is not appropriate for deaf people. There is no specialist provision. They have to go to England to get any specialist help. I'm not sure if you want me to go any further about the experiences that I hear every day, when the deaf community are feeding back to me and talking about awful experiences that they're having at the moment

with GPs in primary care.

[218] **Dai Lloyd:** In response to that, can I just say that there are several questions? We will explore all of those avenues for all of you, all right? So, we'll go into every facet. So, there's plenty of time for you to come back and describe in detail other facets. All right, Michelle?

[219] **Ms Fowler:** Thank you.

[220] **Dai Lloyd:** Karen.

[221] **Ms Kitch:** Three years ago I was diagnosed with early-onset Alzheimer's. I was 51. First of all, when I saw the GP, they said yes, there were memory problems. Then I had to see a psychiatrist nurse who thought maybe I was going through the change, but I'd had a hysterectomy at the age of 42. Then I had to see a psychiatrist because they thought I was depressed, which was a waste of time, because they said to me, 'You're not depressed'. I said, 'I know'. Eventually, then, I got to the memory clinic, and was told that I had Alzheimer's. Because I'm young, people automatically think that I've got something else.

[222] **Caroline Jones:** So how long did the diagnosis take?

[223] **Ms Kitch:** I was very lucky. I was put on the sick in September, and by the January I had the diagnosis. But maybe that was because of my age; because I was so young, they wanted to—.

[224] **Dai Lloyd:** Okay. Nigel.

[225] **Mr Hullah:** I think there's a common element here. I've taken part in all of the consultation events, and the common element is the length of time from the time you first present to a GP to diagnosis. In my case, I come from the free republic of Townhill in Swansea and it took nearly four years for the hammer finally to drop from the time I first presented. One understands that you don't want to misdiagnose at any stage. The difficulty is that people lose their jobs, routinely; they get put into a benefits system that is not good these days; they develop huge financial issues and of course the other partner, if they're in a partnership, is wondering what's going on. It puts a terrific strain on socially.

[226] The strategy is committed to a clearer diagnostic pathway. We don't

think that the diagnosis needs to be a medical one. We don't think there needs to be just doctors involved with this. To routinely park dementia in mental health services we feel probably is the wrong place for it to go. Most disability groups will tell you that they shy away from the medical model of care. We're hoping that the Welsh Government recognises this and will develop it along with the strategy—that we look for a more inclusive, psychosocial approach. Because the early days are days of confusion. You pinball from one agency to another. You don't know what's going on. Things are happening to you. There is a tendency, I think, for people to drop through the net, and the tighter the net is, of course, the less likely it is that people will drop through it. One of the innovations we're hoping for is more dementia support workers, and more peer support. Peer support, we've found, is the best kind of support. It's other people who have been on the journey and are in a position to help. In Swansea in particular, I've a meeting on Monday and we're hoping that every memory clinic will have a cup of tea, a packet of biscuits and somebody like me in the room when the diagnosis is given, as they do with any other disease. So, we're hoping that becomes a national standard.

[227] **Dai Lloyd:** Good. A very comprehensive answer. You've mopped up a few of the questions there, I think. First of all, can I apologise to Madeline for calling you Madeline Cook at the start? I was misled, not for the first time in my life, but, anyway, Madeline Phillips—welcome. Also, while I'm welcoming people, can I welcome, in the public gallery, Dawn Cronin and Anita Tomaszewski, who've also been very helpful in putting all the information together for today and preparing the groundwork for today—a very great thank you, indeed—so that this session runs nicely? Having given you a bit of a warning there, Madeline, would you like to add anything to the situation?

[228] **Ms Phillips:** Hello, I'm Madeline Phillips. I was diagnosed with Alzheimer's last June. I'm a former headteacher and I'm currently setting up a memory cafe in Cowbridge, the first that there has been. I spoke to a group of trainee clinical psychologists recently about life after my diagnosis and used these key words: relief, in finally knowing what was wrong, a new beginning, hope, challenge, humour about it all—very necessary—and, above all, support and understanding. One friend said, 'It is what it is, but we'll be there for you.'

[229] But where does someone recently diagnosed go for support, information and medical expertise? Who is there for us? I think that's very patchy and very bad from what I've heard. Individual professionals have

helped some people, but they're thin on the ground, and there's no obvious pattern that ensures that we've easy and clear access to the necessary help. But, most of all, there's a need for reassurance that we're not alone on our journey. Thank you for listening.

[230] **Dai Lloyd:** Great, thank you. Well done. Emily, would you like to say something? And then we'll move on *i'm hen ffrind*, Beti George. Emily.

[231] **Ms Jones:** My mother was diagnosed just under 10 years ago with early-onset Alzheimer's at a similar age to you, Karen—she was 54. She was very lucky with her diagnosis in that she didn't have to go through a GP process. She was a senior OT at Ysbyty'r Tri Chwm in Ebbw Vale, which is a dementia specialist hospital. So, it was her colleagues who noticed that she was presenting with signs of it and referred her to Dr Bayer at the memory clinic.

[232] The problems came during and after the diagnosis, because I felt very shut out of the process. They would speak in a lot of jargon, which my mother could understand, as she'd worked with it, but I didn't understand. I think maybe they thought—sorry. Maybe they thought she was explaining things to me at home, perhaps, but she never did, because she was in a state of denial. It was just me and my mam at home, so we didn't have—you know, there was nobody at home to have an understanding of it to explain to me. So, I had no knowledge of, really, what to expect, of anything that was going to happen, and, in keeping with that, there was no involvement from social services or anything, really, until six years after her diagnosis. I really feel that had people like that been involved a lot earlier, it possibly wouldn't be affecting me quite so much—sorry.

[233] **Dai Lloyd:** No, that's all right. So, have you got help and support nowadays, Emily?

[234] **Ms Jones:** Since 2014, she's been in a residential care home until the start of this year, when she had to be sectioned and taken to hospital, which is where she is now. She's in a very advanced stage of it, and I just feel that all of this could have been—maybe not prevented, but helped and that both I and her could have been prepared for it a lot better had there been that involvement from not just Dr Bayer, who was great, I don't want to—. But I just feel, especially for carers, that they shouldn't feel ignored. Things should be explained to them. I eventually had my own social worker—my mam had her own—and that helped so much, but it was six years too late by that

point.

10:45

[235] **Dai Lloyd:** Okay. There'll be other questions on the carers front.

[236] **Beti,** wyt ti eisiau dweud **Beti,** would you like to say
rhywbeth? Wel, pawb—. something? Well, everyone—.

[237] **Ms George:** Yes, I mean, this is something that everybody should listen to. Thank you, Emily.

[238] **Ms Jones:** I'm sorry.

[239] **Ms George:** No, no.

[240] I'm speaking in English. I prefer to speak in Welsh, but my friends here, if they find it easier, obviously, I'll speak in English. But it just highlights the problems that Welsh speakers face. I don't know—I don't think two hours would be long enough really, for me to share my thoughts with you.

[241] As it happens, it's very timely, because David is in hospital. He went to hospital last Friday with a chest infection and spent a day in a trolley unit. The trolley was too short for him—he's tall, he's got hip problems, his leg was stuck between the frame, but there we are, that's what the—. He was on a trolley for a day. And then, on Saturday, he was moved into another assessment ward, and on Saturday he was—. We got him up to sit in the chair. Happy as a sandboy—his chest infection was clearing; they'd given him an antibiotic drip. Then that was the last time he was able to sit in a chair—he's still in hospital—because the physios and the occupational therapists found it too difficult to get him out of bed to sit in a chair. And, of course, as you probably would appreciate, the longer he stays in bed, the trouble is that, probably, he will never get out of bed. This is what I thought that the physios and the OTs—. This is what I couldn't understand. Why didn't they see that? They seemed to think that he was going to be bed-bound anyway. So, the experience has been horrendous, really. I was asked, 'Oh, does he get out of bed at home?' Well, of course he does. And then I pleaded with the physios and OTs to get him out of bed, but they said it was too difficult. I'd done it for two years—helping him to get out of bed and dressing him and doing everything for him.

[242] A week later, of course, he's still there and the leg muscles are getting weaker. Last night, I went in—it almost broke my heart. They'd moved him again into another ward. He was disorientated and I said, 'I want to take him home now', but, of course, I cooled down—I do get a little bit too emotional at times, I know. The social worker came and we, at last, felt that there was somebody who was a support there. So, they're meeting this morning—the physios and the community physio—to discuss various aids.

[243] Now, the whole experience has been distressing, not only for David, but for me, also. Person-centred care it was not. There are not enough staff, for goodness' sake. I saw the staff working last night and my admiration for them is unending. It really was an eye opener to see them and I would like to see all of you going to this ward—E7 at Llandough hospital at sun down, or they call it—what do they call it? Anyway, we call it 'sun down' in dementia, it's at about 6 p.m. or 7 p.m. I would recommend you go there at that time to see what it's like for the staff to look after a whole ward—two wards, actually—of people with dementia. Three looking after six—one nurse and two healthcare supporters looking after six. Four of them were wanting to get out of bed and they wouldn't be stopped, so they were wandering around—one had a broken hip, and the other would fall because his legs were giving way under him. And just three staff looking after these six. David was in bed, so he was no trouble at all. Ideally, of course, he should have been treated at home. There should have been an antibiotic drip for him at home. Now the trauma of trying to get him back home is too much, really. The medical people were totally satisfied, the chest infection has gone, and they agree that he would have been far, far better at home.

[244] The whole system is disjointed, there's a lack of communication, there's a lack of understanding, it's all a muddle, and there is not a clear pathway at all. I think what is needed, and I agree with Nigel, is a single named key supporter, link worker, whatever you call them. There is such a system in Scotland—a link worker—but it's only for 12 months. I would argue that this service should be there throughout the illness, and I also see that we need—. This is my way of seeing things. I would like to see a dementia designated unit attached to every health board so that I, in the time of crisis—. By the way, your questions about the GPs—the GP became involved when there was a crisis last year in August and I happened to be away. Since then they've been very supportive. They all say that they don't know enough about dementia. The one who's taken particular interest in David says that he hadn't had any, any inkling of what dementia means when he was trained,

and he's young. I think, though, that has changed now. So, I would like to see this unit with all professionals and disciplines, with specific training for dementia, working together, with one telephone number, a 24-hour service so that somebody like me, at a time of crisis in the middle of the night, could ring this number and everything would be sorted there and then. Because we now have got to ring here for somebody, ring there for somebody, they come from all corners—. I want it in one unit under one—well, not under one roof literally, but—.

[245] I think there's too much focus on dementia-friendly communities. I think you seem to think that that will solve everything, dementia-friendly communities. They haven't helped us because David is at an advanced stage—eight, nine years. I think there's an enormous emphasis on newly diagnosed, which is tremendous, I'm glad that it is happening, but the vast majority, like David, of course, have advanced dementia and they seem to be neglected, and they seem to be forgotten. I must admit that dementia is not as sexy as cancer. We all know if the same amount of money was spent on dementia research as is spent on cancer research, then there could be a breakthrough. It would be much more likely so. In the long run it would save money.

[246] The last point I want to make is carers. They need to be respected. I'm not talking about myself and unpaid carers here, but professional carers. They need to be respected; they need to be paid a decent wage. Ten years' time, down the line, if there aren't any more carers, I don't know, we'll be in the middle of a crisis that we've never seen the likes of before.

[247] **Dai Lloyd:** Ocê, diolch yn fawr, **Dai Lloyd:** Okay, thank you very Beti. much, Beti.

[248] Michelle, and then Julie's got a question.

[249] **Ms Fowler:** Thank you, and going onto a different topic, personally, my father has dementia. When he was diagnosed, I found out through the hospital. I was asking for information and they didn't provide an interpreter, they refused to provide an interpreter for me, so I'd no idea what was going on for quite a while with my father. He was going back and forth, and I had no idea what was happening. Then they diagnosed him—because he had a heart condition and he had a stroke, and they diagnosed the dementia while he was in hospital. I had a text, and I asked if they could only contact me by text, obviously, because I can't use the phone, but they contacted my

brother, but he's deaf as well. We are, really, both next of kin, but they found that difficult. The professionals didn't want to contact me. They were contacting my brother or my daughter, and it was not appropriate. She's a young woman. Why were they only contacting my daughter because she is hearing? It was just easier for them. They don't realise the impact. My father's brother is elderly, and they were contacting him and his wife. They weren't the next of kin, but because they were hearing—they were contacting anybody except me as the daughter, as the next of kin. I was struggling to understand what was going on. The information is not accessible because it's in written English. There's no information in British Sign Language. We need that translated so that we know what's going on. Welsh speakers ask for things translated into Welsh. That's fine, but what about translated into BSL? It's had a huge impact on all the family. It's affected us as a whole.

[250] So, as part of my work, I would really like to network with other people and see what we can do. The complaints procedure is not accessible to the deaf community because it either has to be in a written format or maybe the telephone. They won't provide interpreters. We need to be able to make a complaint in BSL. The whole procedure needs to be explained more clearly. Looking after my father has been so difficult, trying to communicate with him. It affected him. He was getting more stressed and aggressive. It wasn't fair on him because he was struggling to understand me. So, it's really had a huge impact on the whole family. Social services became involved and they regularly booked an interpreter, which was really good. So, I was able to understand then about the care and what was available.

[251] In the end, we had to agree to put him into a care home so that he'd have company and other people to talk to. I realised that company is so important. Communication is vital, and that's made me think even more so of the deaf community, if they were put into a care home where they couldn't have company, because there would be no-one to talk to. Imagine how isolating that would be. Imagine how you would feel if you were put into a care home where everyone was signing or where everyone was speaking Welsh and you were the only person that couldn't sign or couldn't speak Welsh. Imagine how you would feel. It's so isolating. For people that live far away, they might never see another deaf person. They need their own language. The staff, the people that are looking after them, they're all hearing. They'll be speaking. In one situation, the deaf person is becoming aggressive and making a lot of noise and she's been locked into her room because none of the hearing staff or the other residents can cope with her. It's a terrible situation, and that really needs to be looked into. The

experiences that I'm hearing from the deaf community are appalling, to be honest. It's really terrible. They all hope that they don't get dementia in Wales because there is nothing for them. They would have to go to England to have any sort of specialist support.

[252] **Dai Lloyd:** Okay. Point taken. We've got some specific questions now. Julie next, and then Rhun.

[253] **Julie Morgan:** Yes, just listening to the last three contributions, it's obvious that communication and information is a huge issue, and obviously, in particular, with the deaf community. I'd wondered, when Beti told us about her recent experiences in the hospital, whether you felt that you were getting the information that you needed, whether the hospital staff were giving you all the information about why they couldn't do what they said they couldn't do. I just wondered if you could tell us about that.

[254] **Ms George:** Yes. Simply put, they said that it was too difficult to get him out of bed. These are experienced physios and OTs.

11:00

[255] When I was there, they did manage to get him out of bed, and they watched me helping them, and one thing that I noticed, because I've always sort of helped him, under the arm: 'Oh, you mustn't do that. You mustn't do that.' Well, you know, I've done it for two years anyway. I think they're risk averse, really—too much so, at times. The feeling I had is that they thought that he'd never get out of bed again, and that is frightening. If he came home and he was bedbound, it would be very difficult, wouldn't it?

[256] The information: yes, the only thing is that they said it was difficult, and that he would lash out, which he does, sometimes, but not with me. They didn't seem to visualise David at home, and that he was a totally different person at home. They only see it in the hospital environment. I think they must listen to the carer—somebody like me—and have faith in me, that we can cope.

[257] **Julie Morgan:** I think that is a big issue that we'd like to take on board there.

[258] **Dai Lloyd:** Yes, absolutely. Rhun, part of your question has already been dealt with, really.

[259] **Rhun ap Iorwerth:** A gaf i Rhun ap Iorwerth: Can I thank you? ddiolch?

[260] Can I thank you all for your evidence this morning? I don't like calling it 'evidence', really; thank you for sharing your stories and your experiences. On the strategy's aims to increase the numbers of people who have a diagnosis, there is a target of 3 per cent, annually, as an increase. Is that enough?

[261] **Mr Hullah:** Well, we have to support that because it's better than it is now. But, no, it's not enough, and if you look at the other national averages, it's well below. Diagnosis is one of the issues, I think, that we've brought up time and time again, certainly at the cross-party group, and at the task and finish groups. The importance of an early diagnosis is—. It would take another hour for me to explain.

[262] **Dai Lloyd:** Which we haven't got.

[263] **Mr Hullah:** Which we haven't got. So, I'll say it very quickly. People can access very quickly the services, but the early diagnosis is so important to the carers, because they're wondering what's going on. They're sitting there looking at somebody who's changing, and they're thinking 'What's happening?' As has been said earlier, it's a relief when the diagnosis comes along. It's good that the Welsh Government wants to increase its diagnostic level. I would remind you that it's probably still the worst in Great Britain, and it needs a lot more work. To achieve this, you need to push extra resources into things like memory clinics—maybe moving away from a medical model of care. Does a doctor always need to deliver the diagnosis? Does a consultant need to deliver the diagnosis? We don't think so. The consultants think they do, but we don't think so, and it's best placed with what we could consider an appropriately placed person. And, I mean, if you look at the latest releases from the British Psychological Society, on person-centred care, a place to start, it would seem that psychologists play a huge role in this, as the tests leading up to diagnosis are usually all psychological.

[264] **Dai Lloyd:** Dawn, you wanted to expand—. Nigel and Beti have already alluded to this, but carry on.

[265] **Dawn Bowden:** Indeed. Yes. And thank you all for coming. You sharing your experiences, it's been very powerful to listen to what you've been saying. I wanted to ask you specifically about post-diagnosis support. I think

Michelle's evidence has been very powerful, in particular the support for the deaf community. We've got other groups that I think we've identified in previous evidence as not having sufficient support, but, in particular, I wanted to just explore with you a little bit more as to what happened. Specifically, once you got your diagnosis, what level of support did you find, both to yourselves, as those diagnosed, and to carers? Emily, I know we heard you say that it took a long time, and once it was in place, it was good. So, a little bit more about that. And perhaps, a little bit of information about direct experience or experience you know of others where the experiences have been very good, so that we could perhaps learn from those experiences and share the best practice. Because, if you're aware of where that has been good, that might be something that we could be directed towards.

[266] **Ms Phillips:** You asked about support afterwards. I would say from my experience, and I've listened—I'm on the consultative group that meets in the Kymin in Penarth, and it's a multidisciplinary group, but there are five folk like me with dementia of various kinds. They had just been diagnosed. One, I felt, really was not coping at all. The others were extremely upset. I knew what my experience had been, but I was, because of my contacts, able to cope with it. They had nothing. They were just left. In my case, actually, the diagnosis was delivered in 10 minutes, I was with my husband and I was expecting it. Thank you. We were out of the door, and then as we were going through the door, we were told 'Oh, and don't forget to put a'—and I've forgotten the name of it—'health, um, in place.'

[267] **Mr Hullah:** Advance directive.

[268] **Ms Phillips:** Yeah, that kind of thing, 'advance directive in place', [Correction: 'power of attorney in place'], as we went through the door. Now, actually, we knew what that was, but I know that the two people who had gone in before us would not have had any idea. But there really is nothing. Some of us, as I say, like me, can—we've got colleagues who are palliative care, who are whatever, and we can ask. But there isn't anything—even if you ask, you find that. The family doctor, I have found, has been superb, and he has made appointments every three weeks for my husband and myself. But it's bad, and that's why I mention the pattern. There's no obvious pattern.

[269] **Dai Lloyd:** Karen, did you want to add to that?

[270] **Ms Kitch:** I'm fortunate that I have a social worker, but I didn't get the social worker because of dementia. I was diagnosed in the January and in the

May, my daughter was 16. We had a party and part of my dementia is that I fall over. And, I fell over and broke my foot. So, I ended up in hospital for two weeks. My husband had to have a knee operation, so there was nobody at home for me. So, I had to stay there because they wanted to get care in the house first before I could go home, which was fine. The lady came out to see me and the first thing she said to me was, 'Right, who's your social worker?' And I went 'Excuse me? Why would I have a social worker?' 'You have dementia.' 'Uh, nobody's ever told me anything about this.' So, I was fortunate, within two weeks, I had a social worker. It has opened a lot of doors for me, I must say. It's helped a lot, it's helped my family, because I worked in pharmacy and they weren't very helpful. You'd think, being in the medical sector they would be good, but they weren't very good at all. My daughter, she struggles with my dementia. Recently, I separated from my husband because he can't deal with my dementia. So, financially, I haven't got a career anymore. I haven't got a husband, and my daughter struggles.

[271] **Dawn Bowden:** Can I just ask, Chair, have any of you had access to dementia support workers?

[272] **Ms Kitch:** I have a PA. That's with the Dewis Centre for Independent Living. She comes out for 12 hours a week with me; that's the maximum you can have. So, that gives my daughter a break, and used to give my husband a break.

[273] **Dawn Bowden:** I'm just wondering at what point in the process of the development of the condition that dementia support workers are introduced.

[274] **Ms George:** With David, it was eight years before we had any support at all. At the beginning, when he was first diagnosed, we were lucky, he was put on a drug trial, so for about two years, we would go back to the memory clinic every two months or so and we felt very supported and very safe. But after that, when that drug trial came to an end, we were left. And it was only last year when the crisis point came and the GP contacted social services—that was in August. They came out just before Christmas—'Oh, there's not much point in doing anything now until after Christmas.' Then we had an eight-hour care package through direct payments—eight hours, which wasn't much—and then another crisis happened, and then they've upped the care package to 36 hours a week, which means a day and a half.

[275] **Dawn Bowden:** So, it appears to be more like responding to crisis as opposed to a managed process.

[276] **Ms George:** Absolutely. There was nothing before.

[277] **Dai Lloyd:** Okay. Lee, more about—and also, as regards the dementia plan, what would you like to see as regards support for carers?

[278] **Lee Waters:** Absolutely. Can I echo the thanks for your testimony? It's very helpful in informing how the committee challenges what the Government is intending to do. I wanted to ask, specifically around carers and the strategy—the strategy is planning to measure the help for carers. One of the ways it's doing it is by judging what percentage of carers are offered an assessment in order to be given a support plan. I wondered if you have any thoughts about—is a support plan helpful? Is this the best way to judge how carers are supported?

[279] **Ms Kitch:** There isn't a support plan for carers. My husband—he had to research everything on the internet and it still wasn't enough. He had no support whatsoever, and in the end, he couldn't cope with it.

[280] **Lee Waters:** So, what would have helped him?

[281] **Ms Kitch:** It would have helped if we'd had somebody who he could've talked to and he could have expressed how he was feeling and perhaps somebody could turn around and say to him, 'Look, we understand, but what if you try this way? Try that way.' I don't know when my mood swings go. It upsets him, it upsets my family, but I don't know I'm doing it.

[282] **Lee Waters:** No, of course. Are there more informal networks of chat rooms, online communities that exist?

[283] **Ms Kitch:** I don't know. He said there was nothing.

[284] **Mr Hullah:** Well, there are, but you have to be in the know. I think, taking on your point, there's so much research out there—I mean, 75 per cent of care is delivered by unqualified people at home. It's estimated that 50 per cent of people who are in a caring role will develop serious psychological problems from the fact they're caring. Eighty per cent of people in a caring role will feel unsupported and isolated. These are not my figures, these are figures that have been garnered from talking with carers. Taking on everyone's point, the best kind of support for carers is peer support—it's other carer groups, it's other people talking about the issues and the

dimensions of the demands in front of them. Not me, I'm always introduced as Nigel, the man who lives alone in Swansea—I don't live alone with dementia, I've got 10 people maintaining me. Somebody asked for a—I think it was you who asked for an incident of good care. I was diagnosed, as I said, in 2012 and I was left alone and I went up to 28 stone. I must have had a psychological thing of drinking and eating myself to death. And then all of a sudden, these three very annoying women from the young onset team turned up at my door and just wouldn't let me lie—went through my fridge and put me on a diet plan and on an exercise—. It really was annoying. It really was.

[285] **Dai Lloyd:** [*Inaudible.*]—today now. [*Laughter.*]

[286] **Mr Hullah:** That's why I am like I am today. [*Laughter.*] Because, as it takes a village to raise a child, it takes a whole different mix of people to support people living with dementia in the community.

[287] **Lee Waters:** Could I just ask Emily, reflecting back, what would have been useful at the time the problem arose for you?

11:15

[288] **Ms Jones:** Very similar to what other people have said, we kind of left the hospital after diagnosis and there was nothing for six years. But at that point, in 2013, I was given a care assessment, we had a home assessment, but it was my auntie who saw that my mother and I were at crisis point and she got in touch with them. So, the thing that's important to me, I think—the onus should be on the health and care providers to tell people about this, because, unless you know that something exists, you can't ask for it. We didn't. We had no idea who to contact. I was 17 at the time. You think you know everything at 17, and you don't, you know nothing. That was the problem. It took me having, as has been mentioned, severe mental health problems before somebody noticed that I wasn't coping. And I hadn't been coping for those six years and I'm still not now. That's very, very difficult to look back on, at a distance of 10 years, and think, 'Okay, some of the challenges and the mistakes might have been mine, but a lot of them weren't.' And there's nothing that I can do about that now for me, because it's far too late. My mother's at a very advanced stage. But if we can all change this for people who are going to deal with this in the future, then we have to because—listen to the effect that it has on people's lives.

[289] **Lee Waters:** And the support plan, when you had it, was that a useful

thing?

[290] **Ms Jones:** In some ways. Personally, for me, they gave me my own mental health occupational therapist and she was amazing. I honestly don't know if I'd be here without her. There were a lot of other people—support workers—whom I had, and Pas who would come in just to take my mam out for a couple of hours. But, at the same time, the thing that I keep saying is that it came far too late. Things that I've struggled with are now going to affect me for the rest of my life. What was very hard was how mentally ill I got, and having my mother see that, because my mother felt that that was her fault, and in no way was it.

[291] She was also struggling with depression herself, which I didn't realise. So, I think it's also very important, when somebody is diagnosed with dementia or when they are continuing in the process of it, for healthcare professionals to just keep an eye, at best, that they might also be struggling with other illnesses. Dementia is not the end of it. They can then develop all kinds of anxiety and depression problems and, if that goes undiagnosed, that's very dangerous as well.

[292] My mother, in the hospital environment where she is now, she's very distressed. She's lost so much weight, she's stopped eating, she won't walk, and this is all—she'd deteriorated very badly within the two months of her being in hospital; she was as okay in herself as she could be beforehand. And in no way do I want to blame anybody for that. The carers she's got in the hospital are amazing. Like you said, there are three of them to sort of look after a ward of 12 people, and you can't do that. You can't keep your eyes on everybody all at the same time. She's very stressed and unsettled. She speaks but they're not words and they're not sentences—it's garbled. It's very, very difficult to not only have someone who can't maybe remember what they were going to say but now they can't express it in words. I think training for people, carers and for myself, maybe, to learn how to better communicate—because at the moment all I can do is sort of stroke her arm and smile and give her a kiss, because there's no other way I can communicate with her.

[293] **Dai Lloyd:** But that's also the most valuable thing as well. Lynne, do you want to take over? Then we'll have one final question from Angela as regards the staff training issue and that'll be it. Okay, Lynne.

[294] **Lynne Neagle:** Okay. We've had quite a few people tell us that medication can be used in ways when it shouldn't be used. One of the things

I'm really worried about is that medication is being used for people living with dementia when other things should be used instead, whether its support, psychologists, just generally having help to cope with things. Instead, people are being given medication, whether its antidepressants or worse things that can have a really serious impact on people's personality and the way that they are. I just wanted to ask what your views were on that, really, and whether that was something that you're aware of happening.

[295] **Dai Lloyd:** Nigel, do you want to come in?

[296] **Mr Hullah:** We believe that the pharmacological approach is the wrong one and that it really should be the last one. We've had conversations with the older persons' commissioner on this and she's quite concerned, particularly about the use of anti-psychotics in nursing homes in particular and whether or not it's always the appropriate response to somebody's behaviour. You know, how many other things have been tried before they decide on medication? I understand why it's done because it's an easy answer. If you're in a situation where you've got three or four people caring for 10 or 15, it may be the swiftest answer. But they really need to look at themselves—GPs need to look at themselves, not just people with dementia, but generally. I think there's an over-prescription of medication, generally, to the population, I feel. You go in there with a sore throat, you get antibiotics; you're not told to gargle with salt water.

[297] I'm very uncomfortable—I had a personal experience where I was threatened with a section. I was threatened with it because I was presented as being very aggressive. Well, yes, I'm an ex-Royal Marine, so what do you expect? However, what I'm saying, or what we're saying is that as long as every other avenue has been explored and there is good, clinical justification for using anti-psychotics or, in some cases, worse, then fine, but I think that our experiences are that, very often, that is not the case.

[298] **Dai Lloyd:** Angela, just to wind up this session.

[299] **Angela Burns:** Yes, certainly. Thank you very much for your candour, it's really appreciated, and I know that, in different ways, I think most of you have touched on the lack of training in some ways. Beti, I think you made a comment about the fact—I think it was you who said that young GPs are just coming out of medical school and saying, 'I don't know anything about this dementia.' I think that, from you, it's absolutely horrifying to hear that because—

[300] **Ms George:** Things are changing now.

[301] **Angela Burns:** I'm glad to hear it, because it is a condition that is very prevalent and is becoming more prevalent. I just wanted to understand a little bit better what you think we could recommend in terms of more awareness for staff. I think you made the comment: there's no such thing as a dementia-friendly environment; we talk about it, but the reality is so far away. What could we do to help make it more of a reality and not just in the medical profession, but just throughout in terms of trying to train carers and all sorts?

[302] **Dai Lloyd:** Michelle, you indicated.

[303] **Ms Fowler:** I was responding to what Nigel said about the medication, sorry. Can I go back to that point?

[304] **Dai Lloyd:** Yes, go on.

[305] **Ms Fowler:** When deaf people sign, sometimes, they could think that they're being aggressive and being wild, but because they're moving their arms about, they're trying to communicate and trying to talk and they could be given anti-psychotic medication or anything to calm them down when, really, they don't need to be calmed down, they just need someone to understand sign language. When they assess deaf people—you know, they respond in a different way to things. Researchers found, in Manchester, in the mental health specialist service there, a lot of research and the information is there, comparing deaf and hearing people and their responses are completely different and people need to understand that and need to identify the good and bad practice and how to deal with sign-language users.

[306] **Dai Lloyd:** That answers the question on staff training. Beti, did you want to come back?

[307] **Ms George:** I think the Government have set some targets, haven't they, that they want—I think it was by April last year; or, no, it couldn't have been—75 per cent of staff—? They talk about NHS staff in hospitals, but I think, of course, it should also be other staff: the porters, the caterers—everybody. In David's case now, in Llandough, the caterers come and say, 'Would you like a cup of tea?'—of course he can't communicate. He's lost all

his ability to communicate and, of course, I had to say, 'Do you know he has Alzheimer's?'—'Oh. Oh, yes.' And then they put him on puréed meals and they came with a big plate of sausage and mash and gravy and all the rest of it, and I said, 'I think that he's supposed to have a puréed meal', and then they looked—'Oh, yes. Yes, sorry', so they brought a puréed meal. No, I mean, they should be, but how you go about it, I don't know. The Alzheimer's Society have got training sessions—two hours or something. I don't know whether that's enough for people working in hospitals; I'm not sure. And what I found was that, even if they have been trained—. Because I did ask some of them—I don't know what they were; they were healthcare supporters, I think they call them these days—and they said to me, 'Oh yes, we studied online'. Well, you know, studying something online is not the same as actually dealing with people with dementia on the ward. So, something needs to be done. How do you go about it? It'll cost, I suppose—it'll cost a lot of money and, of course, they haven't got the time, because, as you know very well, there aren't enough nurses and other staff, and they haven't got the time to release them to go on these courses. That's another point. So, yes, I wish you luck.

[308] **Angela Burns:** But we could perhaps recommend that training is embedded in the initial training of nurses and doctors and occupational therapists and physios and all the rest of it. May I just add one little extra to my question, then? If you take the medical side of it away, in your day-to-day lives as either people affected with the condition or people who care, are there any other groups of people that you run up against consistently that you think would benefit from having some kind of awareness training?

[309] **Ms Jones:** A lot of the time I think places like banks and things, because me and my mam had a lot of problems, along with the lack of information, with things that I was never told anything about, like power of attorney or wills—things like that. Again, at 17, that's nothing to you. We found it very difficult trying to sort that out at the point that my mother had lost capacity, so it was something that I had to take on myself. It was very, very difficult to get people to understand that she doesn't know this information any more, and I don't know it. Like when we had to switch the house insurance, because I now pay all the bills for the house. They ask you things like, 'What's your roof made out of?' and 'What year was your house built?' I've got no idea at 17—no idea. I haven't got any idea at 27, either, but, you know—

[310] **Dai Lloyd:** Neither has any of the rest of us. [*Laughter.*]

[311] **Ms Jones:** As long as it's not just me. But, you know, going into banks when she'd left her bank card somewhere, or she'd forgotten her PIN, and just having to go in and say, 'She doesn't know it, I don't know it either, what are we going to do?' and they don't know. They don't know ways around it. They go, 'What's your security question?' and I think, 'Well, if she doesn't know four numbers any more, she's not going to know the answer to anything else'. So, yes, maybe people who work in places like banks and, you know, I guess—what do they call them—like civil servants, people that might have to sort out quite serious issues around things that she's forgotten.

[312] **Ms George:** I think this is where the dementia supportive communities—this is where they do very good work, and I would not at any time think of demolishing dementia-friendly communities, and this is where they really are useful.

[313] **Ms Jones:** Yes, but, in my town, which is only a very small town in the Valleys, our local Wetherspoon's is dementia-friendly, which is great if I want to take my mam for a pint, but I don't tend to do that. But, in places that do really need it—we've only got one bank left now, but, places like that, they haven't got that sort of training or that kind of information.

[314] **Dai Lloyd:** Okay. A final comment, then, Rhun.

[315] **Rhun ap Iorwerth:** Basically, I like communication; I used to be in the communication business. If at that time of diagnosis you are literally given a file and on the first page of that file there is: 'This is your contact; this is the information that you need; this is where you need to turn for this; this is what you need to know about links with the banks; this is what you need to know about power of attorney', and so on, would that kind of really, really basic level of communication be a useful start?

11:30

[316] **Ms Kitch:** Probably, but when you have diagnosis you don't want to know that, because I went, for the first two or three months, into meltdown anyway. I didn't want to know anything. So, I think it would be handy to have that information and take it away with you, and then, when you're ready, be able to use it. Because my husband, he had to research everything. With my employment, he got in touch with the Alzheimer's Society and they sent along somebody to go to the meetings with me, because they wouldn't allow

him in the meetings. I was being fleeced of all sorts of things, because I couldn't remember things. So, yes, I think it would be useful to have that, but, when you have diagnosis, you don't want to look at it straight away.

[317] **Dai Lloyd:** Michelle.

[318] **Ms Fowler:** Yes, if you're given a file like that—you know, as a deaf person, we wouldn't understand the information anyway, if it was all in English. What tends to happen is that people in the deaf community, they share stories and rely on each other. So, that's how they get their information. So, the information would have to be accessible, possibly with a QR code at the bottom of the leaflet, so that they could put their smartphones on it and there would be somebody signing it into BSL. That's a suggestion.

[319] **Rhun ap Iorwerth:** I apologise for suggesting that it had to be a physical file. It is the information contained within that file that's what I had in mind.

[320] **Dai Lloyd:** I said Rhun has got the final word; I'm going to say Lynne has got the final word.

[321] **Lynne Neagle:** Just to follow what Rhun said, if someone had said to you, when you had your diagnosis, 'Here is the number of somebody that you can ring if you want to meet up and talk about this', would that have been better?

[322] **Ms Kitch:** Yes. You wouldn't feel alone.

[323] **Ms Jones:** I think something like that would have been useful to me, and I could have contacted somebody. I think my mam probably, like you said, she wouldn't want to know, and she would probably be in denial about it. But, for me, to have that information would be of value.

[324] **Lynne Neagle:** So, if they'd given you, then, a dementia support worker, that would have helped.

[325] **Ms Jones:** If they'd given me the number of anybody that would've helped.

[326] **Dai Lloyd:** Okay. Michelle.

[327] **Ms Fowler:** So, what about deaf people? They can't phone. How is that going to be accessible? They need to see people face to face, and in many cases they refuse to provide an interpreter. I've had the experience myself. I've had no support.

[328] **Dai Lloyd:** That sounds like a recommendation.

[329] **Ms Fowler:** I've had to really, really fight to get interpreter support.

[330] **Dai Lloyd:** Okay. The time is at an end. It's been an excellent session. It's been very valuable to us as a committee, who are looking to scrutinise and, if you like, criticise the work of the Government as regards dementia care planning. I realise that it's been occasionally distressing for yourselves, but it's been extremely powerful testimony as well, which will be forming a valuable part of our report on this. Now, if there's anything—. When you're walking out of here now and you're thinking, 'Oh, Duw, why didn't I say that?'—well, stick it in a letter or an e-mail or any other form of communication to us, and it will also be incorporated in what's been said this morning. Okay.

[331] So, with that, can I thank you all—Nigel Hullah, Madeline Phillips, Karen Kitch, Emily Jones, Beti George and Michelle Fowler? Not forgetting Dawn Cronin and Anita Tomaszewski and everybody else in the public gallery. It's been a totally emotional experience, I realise, for all of you. Thank you very much indeed for your commitment this morning and for your presence. Thank you very much indeed. That's the end of that session.

11:34

Papurau i'w Nodi
Papers to Note

[332] **Dai Lloyd:** We'll move on to item 4, papers to note.

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

Cynnig:

Motion:

bod y pwyllgor yn penderfynu that the committee resolves to gwahardd y cyhoedd o weddill y exclude the public from the cyfarfod yn unol â Rheol Sefydlog remainder of the meeting in accordance with Standing Order 17.42(vi).

*Cynigiwyd y cynnig.
Motion moved.*

[333] **Dai Lloyd:** With that I will move on to the fifth item, which is to move this committee meeting, under Standing Order 17.42, into private session. Are Members happy with that? Yes.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 11:34.
The public part of the meeting ended at 11:34.*