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

03/05/2017

Agenda'r Cyfarfod
Meeting Agenda

Trawsgrifiadau'r Pwyllgor
Committee Transcripts

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad|Biography	Plaid Cymru The Party of Wales
Dawn Bowden Bywgraffiad|Biography	Llafur Labour
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
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

Eraill yn bresennol
Others in attendance

Dr Jane Fenton-May	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Rosemary Fletcher	Cyfarwyddwr Rhaglen, Datblygu ac Arloesi mewn Gofal Sylfaenol a Chymunedol Hwb, Iechyd Cyhoeddus Cymru Programme Director, Primary and Community Care Development and Innovation Hub, Public Health Wales

Dr Ian Harris	BMA Cymru Wales
Dr Charlotte Jones	BMA Cymru Wales
Alan Lawrie	Dirprwy Brif Weithredwr a Chyfarwyddwr Gofal Sylfaenol a Chymunedol, Bwrdd Iechyd Lleol Addysgu Powys Deputy Chief Executive and Director of Primary and Community Care, Powys Teaching Local Health Board
John Palmer	Cyfarwyddwr Gwasanaethau Sylfaenol, Cymunedol ac Iechyd Meddwl, Bwrdd Iechyd Lleol Cwm Taf Director of Primary, Community & Mental Health, Cwm Taf Local Health Board
Dr Isolde Shore-Nye	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners

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

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

Dechreuodd y cyfarfod am 10:15.
The meeting began at 10:15.

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, a allaf i estyn croeso i'm

Dai Lloyd: Welcome to the latest meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. Under item 1, can I welcome my fellow

cyd-Aelodau i'r cyfarfod yma o'r pwyllgor iechyd, a hefyd egluro bod y cyfarfod yma yn ddwyieithog? Gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i hefyd atgoffa pobl i naill ai diffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall, neu eu rhoi ar y dewis tawel? Nid ydym yn disgwyl larwm tân y bore yma, so os bydd un o'r rheini yn canu, mae disgwyl i ni ddilyn y tywyswyr allan o'r adeilad.

Members to this meeting of the committee, and also explain that this is a bilingual meeting? You can use headphones to hear interpretation from Welsh to English on channel 1, or for amplification on channel 2. Can I also remind you either to switch off your mobile phones and any other electronic equipment, or to switch them to silent? We aren't expecting a fire alarm this morning, so if you do hear an alarm, then we'll have to follow the ushers out of the building.

10:16

Ymchwiliad i Ofal Sylfaenol—Sesiwn Dystiolaeth 1: Iechyd Cyhoeddus Cymru a Byrddau Iechyd Lleol
Inquiry into Primary Care—Evidence Session 1: Public Health Wales and Local Health Boards

[2] **Dai Lloyd**: Gyda chymaint â hynny o ragymadrodd, felly, fe wnawn ni symud ymlaen i eitem 2, ac ein hymchwiliad i ofal sylfaenol, clystyrau ac ati. Hwn ydy sesiwn dystiolaeth rhif 1 ar y pwnc yma, ac o'n blaenau heddiw yn y sesiwn dystiolaeth gyntaf yma mae Iechyd Cyhoeddus Cymru a byrddau iechyd lleol. Felly, a gaf i groesawu Rosemary Fletcher, cyfarwyddwr rhaglen, datblygu ac arloesi mewn gofal sylfaenol a chymunedol Hwb, Iechyd Cyhoeddus Cymru? Bore da. Alan Lawrie, dirprwy brif weithredwr a chyfarwyddwr gofal sylfaenol a chymunedol, bwrdd iechyd addysgu Powys—croeso. A hefyd John Palmer,

Dai Lloyd: With that introduction, we'll move on to item 2, which is our inquiry into primary care, clusters and so forth. This is the first evidence session, and before us today in this evidence session is Public Health Wales and local health boards. So, can I welcome Rosemary Fletcher, programme director for the primary and community care development and innovation hub from Public Health Wales? Good morning. Alan Lawrie, deputy chief executive and director of primary and community care, Powys teaching health board, welcome to you. And also John Palmer, director of primary, community and mental health, Cwm

cyfarwyddwr gwasanaethau sylfaenol, cymunedol ac iechyd meddwl, bwrdd iechyd prifysgol Cwm Taf. Croeso i chithau hefyd. Mae Aelodau wedi derbyn tystiolaeth o bob man, yn cynnwys o'r byrddau iechyd lleol ac Iechyd Cyhoeddus Cymru. Felly mae gennym ni gwestiynau gerbron, ac felly, gyda'ch caniatâd, fe awn ni'n syth i mewn i'r cwestiynau hynny. Mae gennym ni awr fach, felly cwestiynau byr; atebion byr. Angela.

Taf university health board. Members have received evidence from many sources, including local health boards and Public Health Wales. So, we do have questions, and so with your permission we'll go straight into those question. We have an hour, so succinct questions and succinct answers. Angela.

[3] **Angela Burns**: Diolch, Chair. Good morning. Thank you very much for coming along to see us. I'd just like to dive straight into where you see the evidence gathering taking place, and what evidence do you have that would indicate that clusters are being successful?

[4] **Mr Palmer**: Bore da. Good morning. I think, in terms of evidence base, we've got to just start with saying it is early days for what we're learning about these new changes around clusters and what each project is achieving within those. But we have, from the very beginning, I think, had a bit of a view about gathering evidence. There are probably two things that we've done that are important. We've commissioned from work from Bangor University, which is helping us to understand the maturity of our clusters, and it sort of builds on initial work that we did to just try and understand how soon we would be seeing results from clusters. How would they mature or shape up? How would they accrue other professions into the system and start working effectively? So, that's a helpful piece of work to have in train.

[5] Attached to that, as well, we've had Pacesetters running for the last two years, which I suppose are slightly a level up from clusters but very much connected to clusters, where we've again gone out to tender to ask for support. But over the last two years, we've had a team working through the hub, and probably in earlier stages with some of the professionals from 1,000 Lives, and they've been working very hard to share peer learning across the health boards. We've had a number of all-Wales national days, where there have been exchanges about pharmacy developments that come from the Pacesetter work and from the cluster work, and that has been a very healthy exchange, and I think that's got to be at the best practice sharing, going at an early stage. So, those two pieces are probably the things that are

going to help us get some on-the-record evaluation in place. But Rosemary is probably a little closer to it than Alan and I at the moment.

[6] **Angela Burns**: May I ask another question before you answer, Rosemary? Because perhaps you can flex your answer. That all sounds wonderfully positive. There are 64 clusters out there. We've talked to a fair number of them, both on rapporteur visits into north Wales and into west Wales, and indeed we've had a session with local clusters for the Cardiff and Valleys areas. They don't have quite such a rosy view. There's a lot of confusion as to how this is going to be evaluated. There's, and I'm quoting, 'not always a shared understanding of how evaluation and data would be collected, managed and delivered.' I've got—well in fact there's just so much I will have fingers in all sorts of papers if I try to read every single quote—but there seems to be quite a difference of opinion as to how the effectiveness and how the objective, which is to relieve the stresses on primary care delivery, are being collated, understood, fed back and, ultimately, evaluated for us to decide whether clusters should go forward or not. So, I just wondered what your take is, because my observation would be: 64 clusters—if you can't get that message out to 64 people, or 64 heads, to disseminate through their organisation, there's a bit of a communication gap.

[7] **Ms Fletcher**: Just to follow on John's point in terms of the work that's being commissioned from Bangor, we're engaging with cluster leads in terms of the development of the tool. So, the tool is in pilot stage. That's being informed by research elsewhere, through Bangor University. They're actually running—well, there's a workshop later today, and there's another one being run in north Wales. That invitation has been issued to all cluster leads because we want to engage them in that tool. It's really for them to test and validate the tool to be able to provide exactly what you say to assess the maturity of the clusters, and the potential for clusters going forward.

[8] **Mr Lawrie**: Perhaps if I could just add in to that, I think there are probably two dynamics going on there. There's clusters as coming together, across a patch—not just about GPs, but the wider social work: voluntary sector, locality managers and so on and so forth—and I think I picked up there the demand for GP services. So, I think what clusters are helping us to do is get practices working together, which they probably didn't do in the past as well, looking at shared areas of risk and sustainability, and, in terms of some practical examples, they've now started to develop a whole series of new sorts of roles that can work at both practice and cluster level, which is relieving pressure from general practitioners.

[9] A very specific example for myself up in Powys is that we've identified a new role called an urgent care practitioner, and they have proved to be very effective. We've now got seven of those urgent care practitioners working across five practices in Powys. I was just seeing some stats yesterday that showed that in one of the practices in Newtown, the UCP—the urgent care practitioner—is now doing 65 per cent of the home visits that were previously being 100 per cent done by GPs. So, I think what we're seeing with these new roles that are being developed, both at practice level and within clusters, is that they are coming in, they're supporting, they're augmenting general medical services with their own skill sets, and they are most certainly helping to manage workload at that kind of level. But clusters aren't just interested in managing demand at GP level, they've got a wider involvement as well.

[10] **Dai Lloyd**: Okay. John.

[11] **Mr Palmer**: Just to come back to your point, I wouldn't at all want to suggest that everything is rosy in the garden. I think we've got some good initiatives in place that are going to help us understand and evaluate clusters nationally, and those two pieces of work that I referenced, I think, will be really helpful. But we're two years into quite a different way of working, and I think it shows real promise, but you've got to make sure, as well, that you're looking to individual health boards to deliver on the promise to clusters, if you like. I think what I do see after two years is if you look at this round of integrated medium term plans for the organisations that have got them over a three-year cycle, and for the one-year plans that are coming through for other organisations that haven't, you do see clusters, I think almost universally now, properly referenced in each document, and in a plan system, it's really important that the clusters are represented. I wouldn't pretend for a moment there isn't complexity and some dynamics around that because these are new into the system, but I would also say, as Alan has just laid out with a couple of examples, there are some really promising developments that are definitely going to scale up in terms of three-year plans.

[12] **Angela Burns**: And I perfectly accept the principle behind your observations. I think, from our viewpoint, what we want to see, or what we want to ensure, is that there has been proper monitoring of both the effectiveness of the initiatives in terms of outcome, and the effectiveness of the use of the money, and whether or not that's created the time excess that we need in order to develop or deliver better primary healthcare. What we

don't want to do is run a system for, say, three or five years, and then start monitoring and evaluating it, and that is what has happened with some of these initiatives in the past. So, we're very keen to understand from you exactly how this is going to be monitored, what you're going to be measuring, when you want to see your first set of measurements, and do you have any benchmarks against which you will level those measurements. That's what we're seeking to see.

[13] **Dai Lloyd:** Okay. Moving on, Julie.

[14] **Julie Morgan:** Thanks very much and good morning. I wanted to ask you about the multidisciplinary teams and how they are developing. What are the advantages and the disadvantages? Are there any themes emerging of the multidisciplinary working?

[15] **Mr Lawrie:** I suppose I answered a little bit of that in the first question.

[16] **Julie Morgan:** You've already said a bit about it, yes.

[17] **Mr Lawrie:** I think that, through cluster working, we're now seeing that all clusters and the practices within them are beginning to see that multidisciplinary working is the way to go. Some have been more advanced than others in terms of that. We're seeing a range of professionals now working at practice level: advanced nurse practitioners, physiotherapists working in practice, pharmacists working as practice pharmacists, triage of a variety of sorts—now probably being referred to a telephone first, but nurse triage and so on and so forth. Therefore, coming together and working as a MDT within a practice—. If you probably went back four or five years ago, you would have had a GP, maybe a practice nurse, and a healthcare support worker. You walk into many practices now, you'll see that range of professionals.

[18] **Julie Morgan:** Is it most practices?

[19] **Mr Lawrie:** Many.

[20] **Julie Morgan:** Many.

[21] **Mr Lawrie:** Not all. You've still got some places where it's very traditional, very GP, and maybe some practice nurses, through to places where you'd get every healthcare professional under the sun, nearly, working

under the roof. I think that's about size, and that's why cluster working is really important. We've got smallish practices actually having some of those resources at practice level—so your individual pharmacist or your individual physio—it's just not going to be as cost-effective or viable, and therefore doing it at a cluster-wide level, it becomes much more effective. In a larger practice, maybe 14,000 patients or 20,000 patients, actually employing ones and twos of those is much more effective. So, in terms of advantages, there's certainly better care co-ordination for the patient, certainly freeing up GP time to work on the more complex patients, and certainly, I think, for us, it is about delivering the prudent healthcare principles. It's providing prudent healthcare—only doing what you can do and so on and so forth.

[22] I think there are some disadvantages. I think we have got issues in terms of being clear about the scope of professional practice between these individuals. We're growing these people quite fast: what's their scope of professional practice? I think we have some issues just in terms of role overlap. Where does a UCP start and stop? Where does an ANP start and stop? And I think we're beginning to get, in some of the larger practices, some issues with GPs in terms of having manage this growing multidisciplinary team and feeling confident to be able to manage a growing number of healthcare professionals when they're used to working kind of on their own. Having a large team is, for some people, very natural; for others, we're going to have to put some training and some skill around that. I think, on the whole, it's a very advantageous way of working, but we've got some challenges that we know we're going to have to work through.

[23] **Dai Lloyd:** Okay. John.

[24] **Mr Palmer:** I'm just going to give a small, specific example. One of the things I think that's important about clusters is that they have allowed a number of smaller initiatives to get running, and there was very strong steer from Ministers at the very outset: let's be creative, let's be experimental, and allow some things to happen, and, in some senses, make sure that health boards get out of the way and facilitate as much as possible for delivery.

[25] So, a nice example: St John's, Aberdare—one of our practices in the Cynon. We've got an interesting mix of young GPs and older GPs in that practice. They have some really strong debates about what they want to do. Coming into this year's cycle of winter planning, they had a whole discussion about—. We had a number of acute exacerbations that have happened in the system, people who we pretty much knew would get unwell during a cold

snap, and we know that, in other years, they have definitely come through into the acute hospital system—they've been a presentation at accident and emergency, and then they've had a slightly unmanaged length of stay and could've been treated much earlier in the system if we'd been alive to that.

[26] Now, we've had a number of initiatives over the years that have been trying to get more upstream, but they've run with the Welsh Ambulance Service NHS Trust this year—a community paramedic scheme. That's been a small group—it's just a team of four that have been working across the region but focusing most of their energies on this practice, and so the whole aim has been to predict the people who are going to get unwell when there's a cold snap, and to get to them early and have a discussion about, 'How do we wrap around you and support you so you don't need to come into the acute system?' That has probably saved, after the initial evaluation that's been done locally—it's looking like it's saved five admissions a week during the winter period. Now, if you scale that up and we were running that kind of model out of every practice in Cwm Taf, you could be looking at either an avoidance or a delay in about 11,000 admissions a year. So, it really is the case, I think, that in micro, some of these things look really promising. The challenge to us now in a planned system—we're in a three-year planning cycle—is now to say, 'Okay, we can scale that up in partnership with other partners to make a bigger dividend from the investment.'

10:30

[27] **Dai Lloyd:** Okay, Jayne—

[28] **Julie Morgan:** I just—

[29] **Dai Lloyd:** Sorry, Jayne has a small point.

[30] **Julie Morgan:** That's fine.

[31] **Jayne Bryant:** On your point about that example that you've given, which is a really good example and showing how creative they can be, but we had evidence from Cardiff and Vale University Local Health Board who were talking about the cluster agenda becoming so demanding that there's limited time to develop networks and generate ideas. Do you think there's enough time to find these ideas and run with it, or—?

[32] **Mr Palmer:** It's an interesting question. I mean, I don't know exactly

where the observation came from, so I'd probably need to know a bit more about it to give you a decent answer, but, again, we kind of need to flip this on its head. If clusters believe that they need to make time, and they can make time to invest in joint working, then I think it's then the responsibility of the health boards to respond and support. So, in terms of team working and team development, if you look across a number of the health boards, what you're starting to see now are appointed clinical leads who have got a locality focus; you're starting to see development managers, who are there to support primary care projects and primary care spend; and you're seeing a mixture of clinical leads coming out of clusters or clinical leads coming from the practice management community—or, sorry, managerial leads from the practice management community, who are appointed to drive this agenda. So, then, I think what you try to get is a mix between drive and energy coming voluntarily from the system, with the support of a contractual incentive, and then health boards investing to make sure that these projects can deliver. Where that's happening, you're seeing pace, and you're getting connection between core funding for primary care, Pacesetter funding that's been trying to push the agenda, and then cluster funding that's seeding lots of interesting changes.

[33] **Dai Lloyd**: Okay. Julie.

[34] **Julie Morgan**: I just wanted to know whether you've made any assessment of what has been the response of the patients to these changes. It is something we discussed when we visited Pembrokeshire, to discuss it with the clusters there, and how accepting people were now, generally—maybe of not going in, and where in the past they expected to have seen a GP, they now see someone else. Have you made any assessment of this?

[35] **Mr Lawrie**: We've done a couple of pieces of work around that, around the triage side of things. We implemented the clinical triage model through our Shropdoc provider into the Newtown practice about a year and a half ago. We thought we'd done quite a good communications plan, but you can never over-communicate, can you? We involved the local community in that, and then I've run a number of patient surveys, and they have been generally positive—generally positive. Similar sort of exercises in the south of Powys where they implemented a different sort of triage system, and, again, I've done some patient experience through our patient participation groups at practice level, and also through the community health council.

[36] I think there is a real question about increasing the amount of public

education around this, though, because moving away from, 'You're going to see the doctor', through to, 'You're going to see the appropriate healthcare professional' and getting that message out there. So, when people do access it, it appears as though what they get is a very positive response, but there's a concern if they haven't accessed it, 'Why am I not getting to see the doctor?' So, I think we've got more work to do both at practice, cluster and health board level in terms of that public message in relation to—. Things are changing; they're changing for the better, but you might not be seeing the doctor—you will have to do some of these things. And where it's working, it appears to be working very, very effectively around that.

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

[38] **Dai Lloyd:** Ocê. Rhun nesaf.

Dai Lloyd: Okay. Rhun next.

[39] **Rhun ap Iorwerth:** Bore da i chi i gyd. A allaf i sôn ychydig bach am weithlu? Rydym ni fel pwyllgor, rwy'n meddwl, wedi adnabod cynllunio gweithlu fel un o'r problemau mawr sy'n ein hwynebu ni yn y gwasanaeth iechyd yng Nghymru. A allwch chi sôn rhywfaint am faint o her ydy sicrhau gweithlu priodol er mwyn i glystyrau allu gweithio'n effeithiol? Ac yn benodol, a ydych chi'n credu bod y rhagdybiaeth yma yn gywir: bod y ffaith bod yna drefniadau i rannu staff ar draws clwstwr eang, ar draws y gweithlu amlddisgyblaethol ehangach, yn ffordd ynddi'i hun i fynd i'r afael â rhai o'r heriau gweithlu yna?

Rhun ap Iorwerth: Good morning to you all. May I mention the workforce a little? We, as a committee, I think, have recognised workforce planning as one of the major problems facing us within the health service in Wales. Could you talk a little bit about how much of a challenge ensuring an appropriate workforce is for clusters to be able to work effectively? And specifically, do you think that this perception is correct: that the fact that there are arrangements in place to share staff across clusters, across the multidisciplinary team more widely, is a way in itself of getting to grips with some of those workforce challenges?

[40] **Mr Palmer:** I think this is one of the areas where we've got some of the greatest challenges, so I think it's just worth being honest about that. The Minister has put a taskforce in place for Wales to look seriously at the workforce issues we have around primary care, and there have been some incentive packages recently that have come out that have been very positive. So, in the areas that have been targeted, we've seen something like a 16 per cent improvement in GP take-up, so that's good news, but I think one of the

things we've been challenging ourselves as a network of primary care directors with is: how do we get clarity on long-term modelling around workforce needs, against the need that's expressed in our population? So, we're in the middle of some really serious modelling work with workforce and OD directors, and the workforce, education and development services, who are giving us data and statistics as well. We've done an initial piece of work around that for the taskforce, but I would say it needs a lot more work. So, I think, cards on the table, we've got some challenges to name exactly what the demand profile is going to be over the next five to 10 years.

[41] However, having said that, I also think there's, again, some real promise in the system. Alan's already laid out a couple of examples around multidisciplinary teams developing. On my own patch in out-of-hours at the moment, I just seem to be experiencing a turn where we're starting to develop a much more mixed approach to out-of-hours. GPs are in the lead, but working with community paramedics, who have started to come on stream as a workforce, and working with advanced nurse practitioners, and we just seem to have hit a seam, a bit of a tipping point, where we're getting these people in to work together collectively.

[42] In terms of a day-to-day sustainability, one of the absolute clear priorities that's come out of the Pacesetter funding has been investment in things like primary care support units. So, in Cwm Taf, we have a well-established model of having a multiprofessional team that's available to support practices that really need us to support them and to provide salaried professionals.

[43] When you look across Wales, certainly over the last two years, we've seen investments in similar sorts of things: very focused, professional, available posts that can go in at short notice to provide sustainability support. So, there's been an immediate response in the system, and I think that's just helped to provide a bit of stability over the last couple of years, but we've got to bridge from that. I think the ambition has to be that we're not in a constant wrestle of sustainability. What we want are the right number of facilities on each patch around Wales, that have really good estate, that bring in a multiple group of professionals who can work together effectively for patients. And I think we're laying foundations for that at the moment, and then, as I said earlier, we've got to push ourselves to really get the workforce modelling right over the next five to 10 years.

[44] **Mr Lawrie:** Just to add to that, I think on the one hand we can look at

the work that has been done across a number of health boards and say there are some really innovative roles in there, some big changes, really, that have been over the last couple of years. That's very positive, but there is the same quantum of physiotherapists, pharmacists, nurses and so on and so forth. The jobs that we're creating are interesting and exciting jobs, so therefore people are attracted to those. That's going to create potential recruitment problems elsewhere in our system, whether that's in our community hospitals or in our district and general hospitals, potentially, et cetera, because they see an exciting job working in a practice or at cluster level. So, I think there's a big job, linking to the work that John was talking about in terms of modelling. So what should the supply look like coming into the pipeline as you move forward? This isn't just about solving a problem for now. It is about how we continue to work on that problem over the next five to 10 years, so the supply chain into those professions is really crucial for us, and in terms of an absolute number for that, I'm not sure we're there yet, but the modelling work will help us get to that.

[45] **Rhun ap Iorwerth:** Have you got any thoughts on this?

[46] **Ms Fletcher:** You commented specifically on whether the perception is correct about sharing staff across clusters, and I would say we have to consider that new model, because some of the staff—. You have to have that critical mass. A practice, in isolation, may not be able to fund, or resource, or have the demand for that particular professional, but by looking across a cluster, you can, then, get a better range of professionals who can serve the needs of the whole cluster. So, that's why, personally, I think it is correct that, where it is appropriate, it is considered at a cluster level.

[47] **Rhun ap Iorwerth:** And both, certainly the two of you from the health boards, admit that we're currently probably still at a position where you're trying to recruit from a fairly small pool of people who have the right skills. What is the key, do you think, as a national lead, to making sure that, in the long term, that's not going to be the case? Is that the work of the taskforce that's going to be at the heart of that?

[48] **Mr Palmer:** I wouldn't say it was just the taskforce. The taskforce has a number of things that it's trying to do, but, really, fundamentally, attracting the workforce is about reputation. Do practitioners feel that they're coming to a place that is stable and safe? For me, over the last couple of years, that's probably been the biggest part of the agenda—making sure that our core functions feel stable and safe. Once you start that, you start to generate a

reputation for being a place where people want to work, because they've got that environment. Then, next what you're looking for is a sense that you're going to be able to express yourself clinically. So, there are opportunities for innovation and redesign and clever service design. Again, because I think the cluster space has been a bit more innovative—it's a bit more pacey, it's a bit more exciting—I think we are seeing some of those expressions. So, I pretty much feel that clusters have certainly pulled us into a pharmacy space at much greater, rapid steps than we would've expected otherwise, and a lot of the cluster funding, without a big hand of organisation, has tracked towards pharmacy.

[49] The other thing that's happened is that information and communications technology has become a feature of the landscape, bottom up. You're seeing models like webGP that triage using online systems and are definitely helping some practices, and you're seeing Vision and other online services being put in place to co-ordinate medical records viewing and taking of the record in someone's house, building on some of the interesting stuff we've seen in district nursing, for instance. I think we're seeing pace in a different way, and I think what that does is it creates a dynamic that asks us a question in our leadership roles, within our own health boards and at the national level: can we match that sense of ambition? Can we respond in a planning cycle to scale some of these things up actively? That's on us. That's our responsibility and accountability as leaders in NHS Wales.

[50] **Rhun Ap Iorwerth:** I think the reputation point, in particular, is very important.

[51] **Dai Lloyd:** Symud ymlaen i faterion cyllidol, ac mae gan Caroline Jones gwestiwn.

Dai Lloyd: Moving on to financial issues, and Caroline Jones has a question.

[52] **Caroline Jones:** Diolch, Chair. Good morning. I'd like to ask a couple of questions, please, about funding, particularly regarding cluster development moneys. We've heard that the allocation process is unclear. We've also been told that the moneys are not targeted effectively and that they should go directly to clusters. Could you tell me if these concerns are justified, and, if they are, how do you think the moneys may be deployed effectively in the future?

[53] **Mr Palmer:** Again, I think we'll continue with the theme of honesty this morning. So, I think we all know that, over the last two years, there's been

some variation across the system, and certainly we've got mixed feedback about how clusters feel about how allocations have been handled. But, I take you right back to the beginning, when the previous Minister, before we had Cabinet Secretaries, came out to us very, very clearly, as a whole system, and it was, 'Look, we are sending out £6 million directly to clusters. You must keep out of the way, health boards, and we want experimentation. We want to see pace and experimentation. Let a thousand flowers bloom.' I think that's been a real challenge for a number of health boards. We do tend to like our orthodox planning approaches. We do like to be in our IMTP cycle, because there's an expectation of us delivering against that plan. So, it's a different ask, and I think what I've seen over the last two years is a number of health boards grapple with that challenge of moving from controlling funding to facilitating the delivery of funding and supporting clusters to do what they feel they need to do at a population health level.

10:45

[54] I would say that, over the last six months, we've probably really worked that through in the system. There have been some really important conversations over the last six months that have made it very clear to everyone that the expectations, going forward, are that all the funding goes out absolutely directly. There is an absolute expectation that we facilitate and support, and if we can join up funding, all the better. I would like to say that I am seeing some progressive work now, where health boards are facilitating and making connections between the dots. So, think about the funding packages: we had £30 million out for core funding for primary care, which has been a really important lever overall; we had £4 million for Pacesetter work, to be a bit more radical; and we had £6 million directly out to the clusters. In an integrated system, I think the challenge—and a challenge that I think a lot of organisations are stepping up to now—is to connect the dots so that there is balanced, integrated funding across the whole of the patient pathway.

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

[56] **Mr Lawrie:** Can I just add to that? I think we can't get away from the fact that the funding for clusters has been positive. It has been a positive thing. The fact that it is recurrent has allowed people to plan a little bit more. I think it has also provided a real focus at clusters and it has surfaced some of the issues between various groups. Actually having to make decisions between four and five practices and other professionals has surfaced some of

the issues that they have got to work through. I think, sometimes, that has probably slowed the process down a wee bit. We recognise, I think, that some health board systems and processes have got in the way—so, recruitment, procurement rules and so on and so forth. We probably haven't been as good as we could have been, in terms of trying to work that through with the clusters.

[57] I think we talked a little bit more previously about the support that is required to be provided to clusters. So, I think it is about health boards getting in there, and, if they are getting difficulties in relation to getting a job advertised or matched, or whatever it may be, helping and facilitating that, as opposed to just letting it languish. I think, often at cluster level, they are used to things happening very immediately. In a practice, you could appoint someone tomorrow, really. In a health board, you can't do that because of the various checks and balances that are in the system. So, I think that helping clusters navigate that is really important. Where we have got those identified at health boards where there are some of those difficulties, as directors across the piece, we have been trying to work with those areas to try and say, 'This is what we do in this area. That might be an approach that they could use.' You don't want to be reinventing the wheel across the seven health boards.

[58] **Caroline Jones:** No, but when there's a success story, you wish to share it.

[59] **Mr Lawrie:** Yes, you want to share it.

[60] **Dai Lloyd:** Okay, John, you had an additional point.

[61] **Mr Palmer:** Just very quickly. Just to give you further reassurance, I think that one of the things that typified the approach in year 1 was that everyone just worked hard to get the money out—very much directed by the clusters. If you looked at the spending patterns, you therefore saw a lot of in-year spend on equipment, for instance, which was needed but probably wasn't ambitious in terms of really pushing the agenda around different types of care models. What we have seen in year 2, I think, with a bit of maturity and a bit of everyone understanding the challenge, has been a bit of excitement around clinical service design. So, we have seen clusters coming forward and saying, 'We really want to negotiate some service-level agreements with the local authority to provide social workers in the system, or we would like to do something around pharmacy and commission that on

an SLA', and, most importantly perhaps, SLAs for mental health services. So, MIND is popping up in a number of cluster areas, providing mental health counselling in practice. So, one of the areas where health boards have been able to help is to give a bit of support on commissioning. So, again, it is moving us from a position of regulating to facilitating and supporting, to help organisations that aren't used to doing multi-year service level agreements.

[62] **Caroline Jones:** Finally, we have heard that the funding is short term in duration and is limited, and that 90 per cent of the money is spent on salaries. I wonder if you could tell me if this gets in the way of real innovation and testing.

[63] **Mr Lawrie:** Certainly, the cluster money is being—. We have had it for the last two years, and I think the understanding that we have with colleagues in the Welsh Government is that that money will continue. So, we have been working on the basis that people can plan over a longer period of time, so, doing, as I think John was describing, some fairly short-term things in the first year, but actually getting into the service redesign and interesting spaces in subsequent years. So, we have just received our year 3's worth of funding, with the expectation that that is going to be there in year 4, year 5 and year 6. I think we have to work on that basis. So, it's not short-termism. I think we are now starting to see people thinking very differently about it. But, it is a relatively small element of the total amount of spend that happens in primary care in a particular patch, and, I think, seeing it in the round, that element can actually be the lever to change something, using it that way. If it all gets spent on lots of staff in year 2, then you haven't got any area for innovation and development as you move forward into year 3. So, I think that one temptation that we've had to date is to spend a little bit of it recurrently, but to have some headroom to allow you to use that money creatively as you move into year 3, year 4 and so on.

[64] **Caroline Jones:** So, is the 90 per cent incorrect, then?

[65] **Mr Lawrie:** It wouldn't be 90 per cent from a Powys perspective.

[66] **Caroline Jones:** Okay.

[67] **Ms Fletcher:** Could I just comment on the Pacesetter funding as well, because the Pacesetter funding is there to promote innovation? There are 24 projects operating across health boards, but the attention then is where

those Pacesetters are demonstrating real value, therefore, looking to the health boards then in terms of how they may be mainstreamed so that the funding can be released to test out other ways of working. So, I think that's part of that process in terms of investing and trialling things that are working well—to roll-out and share that practice as well across clusters and across health boards, but then reinvest in new areas of innovation to test those out, going forward.

[68] **Dai Lloyd:** Okay. Angela's got a brief point on this.

[69] **Angela Burns:** Just a really quick one. John, you were talking about the fact that the trust was supposed to be innovative and dynamic—you know, 'Health boards, get out of the way'. You hold the money, therefore do the health boards also decide whether or not a trust can go ahead with a particular initiative, because some of the feedback that we've had is that that's the blockage and, therefore, that's stopping that innovation and dynamism. So, where, if a cluster has 10 per cent of all of the primary care health funding that goes into primary care from the Government, do you just say, 'There you are, sure, whenever you want it, just apply for it' or do you make them jump through hoops? A direct quote that I've just read was that clusters are overregulated and cannot breathe.

[70] **Mr Palmer:** I can't, I guess, answer on the specifics, but what I know is that every health board, through their chairs, through their vice chairs, through their chief executives, through their directors of primary care and mental health, have received a very, very strong message, which is that the funding goes out directly to the clusters and that we must support and facilitate. So, I appreciate that there's been some variation in that, and I think I referred to that in my previous question, but it is very clear that that is the way that this must be approached.

[71] I've been, very recently, out with the confident leaders programme, where I had a full representation of clusters from across Wales and we talked though a number of these dynamics. I would say that it's definitely getting better and that the concerns that might have been in health boards about regulation and financial regulation have probably been allayed because we've seen a bit of trust develop over the last two years between health board finance and HR teams and local clusters. It's up to us, again as leaders in the system, to make sure that this is done properly and well and that clusters are able to express themselves at the local level.

[72] **Angela Burns:** To be absolutely clear, and you can obviously only speak for your health board, in your health board, does a cluster have to have a project signed off by the health board before they go ahead and do it?

[73] **Mr Palmer:** No.

[74] **Angela Burns:** They can just decide to do that.

[75] **Mr Palmer:** They can, but what I'd want to say to you is that that should be the least of our expectations. Where I know that our system is, because we have two monthly meetings with our cluster leads and my senior team attends all of those, we're beyond that discussion. That's my strong view. So, what we're talking about is how we join up funding. So, we're doing a piece of work, for instance, on early stage cancer diagnosis at the moment, where we're importing a model from Denmark. In that, there's going to be a contribution from the clusters—it'll probably be more about engagement and drive than them putting finance into the model. I'm putting investment from radiology on the secondary care side of the business and I'm putting investment into new roles that are in the interface, and I'm investing sessional time in both GPs and acute physicians. So, from my point of view, everything from here has to be about knowing that we've got the fundamentals sorted and that we're putting investment into the integrated pathway so that everyone pulls together and benefits. Because it is when we get the multidisciplinary team not just working locally, but across the whole system that we drive real value for the patient. So, I'm very confident that we're going in the right direction. I very strongly feel that on my own health board patch, of course, but I do see it in the other six as well.

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

[77] **Jayne Bryant:** Thank you, Chair. We know how important it is to have a workforce based on population health needs and focused on early intervention. I think, John, you mentioned that earlier in one of your answers. And I know from my own health board, in Aneurin Bevan, in Newport, that there's excellent work going on with the older people's pathway and work with pharmacists. How effective do you feel that the clusters are generally in tackling health inequalities?

[78] **Mr Palmer:** Again, it's early days, but, in policy terms, what's been made very clear is that we're expecting clusters to operate in a population health environment, and I see some good, developing opportunities around

all of this. Clusters have been well engaged and effective in, for instance, the inverse care law work that we've been doing on cardiovascular risk that has started in Aneurin Bevan and Cwm Taf. So, in some senses, this is a behavioural management intervention. What we're doing is we're working off our general practice lists, we're trying to stratify our lists and target people that we know are vulnerable, particularly to issues around cardiovascular risk. And then we're running a programme of health checks where we welcome people into that environment, and we do some very simple things. We give people a view of their risks, in terms of smoking, alcohol, their lifestyle. We show them their likelihood of having a major cardiac incident in the next three to five years, and we tell people what their heart age is roughly. And that very simply expressed, very health-literate kind of model has had a really big impact both in Aneurin Bevan and in Cwm Taf, working with quite deprived communities, and the clusters have been helpful in engaging with that. I'd say, at early stages, because this started just at the beginning of the cluster cycle, the model was probably a little bit too health board dominated and therefore a little bit too far away from the patient, perhaps. Clusters have been able to engage with our work and help us to get much more into local people's behaviour, community behaviour, and so on. So, that model's now rolling out across Wales. I think that's very positive and it's helping us to think about closing gaps.

[79] **Jayne Bryant:** So, you think clusters are flexible enough to be able to react quickly to those things.

[80] **Mr Palmer:** I referred to the early-stage cancer diagnosis stuff earlier. So, the opportunity there, for us, is to remove gatekeeping culture from the system and to trust GPs' gut instinct about whether the person in front of them has got cancer or not, and to look for a much earlier diagnosis as a result by really driving that referral through radiology. You can make that system work as well as you want, but if you haven't got the community with you, then you're not going to make a massive difference. So, I think, in the Cynon, where we're going to pilot this from 1 June, we've got 40 GPs that have come through the cluster, that have massively engaged in the project and have really brought it energy and excitement, and they're there, actively looking for referrals that they can make in when they have a gut instinct that someone's got cancer.

[81] They now need to help us, not just do that bit, but reach out into the community, talk to people about, 'Why are you so frightened? What's happened to you through the life of your family that means that you feel so

frightened about presenting with a query around cancer? What can we do to help?' So, for me, that is the next step. We can talk all the technical improvements, but I really think that clusters now, with a multi-professional team and people working from social work, people working from a mental health angle, have got to help us reach out, and reach out and in, to our communities, express their voice, and help us to really fundamentally change behaviour so that we can get to grips with outcomes that haven't shifted for a long time.

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

[83] **Mr Lawrie**: Perhaps it's a little less sophisticated, I think, in Powys, in that identifying health inequalities across the patch is a little harder, but the issues of rural isolation are certainly an issue for us in mid Wales. And I've seen clusters actually being very proactive in relation to bringing people into their cluster meetings—so, the community connectors, for example, that are employed through the voluntary sector organisations, the investment that they've made in Mind and working with some of those elements, and also some frailty healthcare support workers who are going out there proactively, engaging with over-85s in distant communities. And they picked that up as an issue that they saw absolutely for their population. So, I do think they've got a mindset now that is around where they've got the most vulnerable people, what they can do at cluster level to support that, which they may be not be able to do just at individual practice level. So, I feel quite confident, really, that they have that in their sights, because that whole emphasis should be about looking at the health needs of the local population, and it'll be different, depending on where you are across Wales.

11:00

[84] **Ms Fletcher**: Just to comment on that, obviously the relationship of the local public health teams with their clusters is really important—having the information base in terms of understanding health inequalities and how it applies locally and then, what the evidence is in terms of how those may be addressed. So, again, as part of that wider cluster team, the local public health teams are very important in those relationships.

[85] **Dai Lloyd**: Mae'r adran olaf o gwestiynau o dan law Dawn Bowden.

Dai Lloyd: The last questions are from Dawn Bowden.

[86] **Dawn Bowden**: On the answer to the first question from Angela, when

you were talking about perhaps mixed views about how well the clusters are working, I know John is in my area in Cwm Taf and I've met with the cluster leads there and the chief executive and the chair and there seems to be a very positive view, but that may not necessarily be the same everywhere, and I accept that. Where there is not such positivity—because obviously, what we want to do is roll out good practice—where there is not such positivity around the clusters, has that been, do you think, partly about the involvement of other professionals and the consultation and involvement of them in setting up the clusters—that it's been too GP-focused?

[87] **Mr Palmer**: It's complex, isn't it? When you think about how you get something up and running and established, you're going to have a lot of stakeholders involved and so, I think, at the two-year point, we're broadly seeing a system that's maturing faster than we would have expected it to. There's loads of variation, because we set out to experiment and that means that we've seen lots of different things happen from community to community. So, one of the issues for my own patch, and I know for others, has been that some clusters grew too big, too quickly. So, what they ended up with was loads of stakeholders around the table and then an almost completely unmanageable agenda because, just like we have big meetings with lots of stakeholders around the table at Government level, health board level and delivery level, clusters were sort of entering into that space and trying to get consensus.

[88] What we're seeing now is a number of cluster organisations finding ways of having both a core conversation about what they're trying to do now, but also developing space for broad discussions across the contractor professions and then they're bringing that boiled conversation into their main governance space, if you like. Again, I wouldn't want to say that any one part of the system is far away from another. It's just that we're all on a slightly different journey. But, I would re-emphasise the point: I think that on the areas where we have concerns, or where the Minister has had concerns, there have been direct conversations and interventions at chair level and vice-chair level to make sure that the expectations are understood and that there's really good peer discussions about how everyone supports clusters. It's very clear that there's a long-term commitment to clusters. So, I do see the system maturing.

[89] **Ms Fletcher**: Can I just comment in terms of investing in cluster leadership? The confident leaders programme, which John had mentioned, has taken in excess of 40 of the cluster leads through a development

programme in two cohorts. There are nine modules and they've been meeting on a monthly basis. That's providing a networking opportunity for the cluster leads so that they can share and also they're learning and developing together. So, there have been a number of modules in terms of governance, legal and value-based healthcare. So, there's been a variety of modules to help them in terms of undertaking their roles and progressing the clusters and there is huge enthusiasm coming from those cluster leads.

[90] **Mr Lawrie:** I think, again, I take the view that, linked to that—. I think we probably did start two years ago with a very strong emphasis around it being GP driven, and I still think that there is a role for those GP networks within a cluster domain to actually work together, because there is some business that is very specific to GPs. They need to be able to get together and thrash that out. And, I think, if we—'water it down' is probably not the right word—but if we involve too many people in that, then they won't have those conversations. There is something about them having that higher layer of primary care cluster, to which GPs are a very, very important part, but you have actually got the right level of stakeholders around it. I think what we're seeing across the health boards is those two functions that are starting to work more effectively together, so it's GPs absolutely coming together where they need to, being supported by the health board, but actually, the cluster being much wider. I think one of the key issues for us though is about making sure that clusters have got an influence at health board level. If a cluster does what a cluster does, and, actually, at health board level, no-one takes any notice of their development plan, or their aspirations, and they're not able to input into clinical strategies, service redesign, and so on and so forth, then I think people become a little bit disenfranchised. So, I think it's a really important point for us to make sure that the work of clusters is providing the bedrock and is providing that bottom-up approach, even into things like IMTPs, so that you expect the IMPT to feature a lot of the things that are happening under the development issues at cluster level. I think there's a responsibility on health boards to ensure that that connection's there, or we'll find ourselves in a few years' time with clusters sitting over here somewhere disjointed from the health board.

[91] **Dai Lloyd:** Okay. John.

[92] **Mr Palmer:** Just very quickly. I think there's a developmental opportunity that we're just scraping the surface of at the moment. But, we've got to remember that we've got a prevailing legislative context around the future generations Act and the social services and well-being Act, that I think

give clusters a real opportunity. So, again, we're just beginning to see now clusters starting to come into the space more formally in social services and well-being arrangements, and on the edges of public service boards. So, they're coming forward with their cluster plans and saying, 'Look, we've got two or three major things here that we're trying to do, would the board want to support us?' So, then, you see the opportunity for us to start to bring together blocks of primary care funding and the integrated care funds, and in that way getting another opportunity to build more mature, stronger projects. So, I expect that to gather pace over the next 12 to 24 months as well, and then we can really start to get clusters into the space about, 'What do our communities look like? What's the shape of our communities over the next five, 10, 15 years?' And I think, then, they can start to live the population health challenge that's been put to them.

[93] **Dawn Bowden:** So, as the clusters mature, then, do you see there being less of a role for the health boards, and this being more driven by the clusters with the health boards being the funders, and maybe the facilitators—I think that's a word you used earlier—and that it's actually the clusters that will drive this forward?

[94] **Mr Palmer:** I would say it's about—. This is a really sort of official answer, so maybe you'll have to talk to me about it afterwards, but I think it's about balance across the system. So, the example I gave you earlier about early stage cancer diagnosis, that needs investment in every part of the system to be effective. So, I need to get investment into the local community to promote awareness. I need to get investment into our GPs and our other professions, so they feel that they've got time to make an assessment based on their gut about cancer presentation. I need to invest in radiology, because if I increase the demand, and I'm after increasing the pick-up rates, I need to invest there, and I need to make sure that there's acute physician and oncology sessions available to then service that demand. Then, hopefully, I get through the bump, and I'll be seeing the same people, just earlier, and they'll be coming to us at stage 1 and 2 rather than stage 3 and 4. That's a blended investment at every stage of the pathway. If we're going to be a mature system that changes outcomes, I really feel that's the way that we've got to tackle it, and I would say that clusters are an absolutely essential part of that patient journey. So, of course we'd want to invest in that.

[95] **Dai Lloyd:** Dyna ni. Diolch yn **Dai Lloyd:** There we are. Thank you fawr. Dyna ddiwedd y sesiwn, dyna very much. That's the end of this

ddiwedd y cwestiynau. Diolch yn fawr iawn i'r tri ohonoch chi am eich tystiolaeth y bore yma. Gallaf hefyd roi gwybodaeth pellach i chi y byddwch chi yn derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau bod beth rydych yn ei ddweud yn ffeithiol gywir. Felly, gydag ychydig eiriau fel hynny, a allaf ddiolch yn fawr i chi am eich presenoldeb? Rwy'n cyhoeddi i Aelodau y bydd egwyl nawr am 10 munud—ac i ddod yn ôl i fan hyn am 11.20. Diolch yn fawr.

session and the end of the questions. Thank you very much to the three of you for your evidence this morning. Could I also give you further information that you will receive a transcript of this morning to check for factual accuracy? So, again, thank you for your attendance. I'd like to announce to the Members that we will now have a break for 10 minutes. Please be back here for 11.20. Thank you.

Gohiriwyd y cyfarfod rhwng 11:09 a 11:23.
The meeting adjourned between 11:09 and 11:23.

Ymchwiliad i Ofal Sylfaenol—Sesiwn Dystiolaeth 2: BMA Cymru a Choleg Brenhinol yr Ymarferwyr Cyffredinol
Inquiry into Primary Care—Evidence Session 2: BMA Cymru Wales and Royal College of General Practitioners

[96] **Dai Lloyd:** Croeso i adran ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon wedi'r toriad. Rydym yn symud i mewn i eitem 3 a pharhad efo'r ymchwiliad i ofal sylfaenol ynglŷn â chlystyrau. Hon yw sesiwn dystiolaeth 2. Fe gawsom ni sesiwn dystiolaeth 1 cyn y toriad. Yn y sesiwn dystiolaeth yma mae BMA Cymru a choleg brenhinol y meddygon teulu o'n blaenau ni. Felly, a allaf i groesawu i'r bwrdd Dr Charlotte Jones, cadeirydd pwyllgor meddygon teulu Cymru y BMA; Dr Ian Harris, aelod o bwyllgor meddygon teulu Cymru a phwyllgor meddygol lleol Morgannwg; Dr Isolde Shore-Nye, coleg brenhinol y meddygon teulu; ac hefyd Jane Fenton-May,

Dai Lloyd: Welcome to the latest section of the Health, Social Care and Sport Committee after the break. We are moving into item 3 and continuing the inquiry into primary care regarding clusters. This is the second evidence session. We had the first session before the break. In this session we have BMA Cymru and the Royal College of General Practitioners before us. So, I'd like to welcome Dr Charlotte Jones, chair of BMA Cymru's general practitioners committee; Dr Ian Harris, member of the general practitioners committee Wales and the Morgannwg local medical committee; Dr Isolde Shore-Nye, Royal College of General Practitioners; and also Jane Fenton-

hefyd o'r coleg brenhinol meddygon teulu? Croeso i'r pedwar ohonoch chi. Rydym wedi derbyn tystiolaeth ysgrifenedig helaeth ynglŷn â chlystyrau ac ati, felly fe awn ni'n syth i mewn i gwestiynau. Mae gennym ni rhyw dri chwarter awr; fe awn ni'n syth i mewn i gwestiynau. Fe fydd yna ddigon o amser i fynd i mewn i fanylion, ac ati. Felly, fe wnawn ni ddechrau efo Angela.

May, who is also from the Royal College of General Practitioners. Welcome to all of you. We have received extensive evidence regarding clusters, so we'll go into questions. We have about three quarters of an hour; we'll go straight into questions. We will have plenty of time to go into detail. So, we'll start with Angela.

[97] **Angela Burns:** Thank you, Chair. Good morning. I've just got a couple of series of questions that are about the evidence and the data collection to evidence how successful cluster working is being in terms of reducing demand on GP services in particular, and making a better transition through primary care. I'd also like to tie my questioning to evaluation and how it's going to be evaluated in the end, and if I skip neatly to the BMA evidence, there's a comment in here that says:

[98] 'Thus far the benefits of cluster working, in terms of transforming primary care for the benefit of the patient and GP across Wales, are not as tangible as we would expect at this stage of their existence'.

[99] We've just seen representatives from local health boards and Public Health Wales to talk about this, and we're really struggling to get an understanding of how this is going to be evaluated, monitored and benchmarked.

[100] **Dr Jones:** Okay. I'll start off, then, if I may. The clusters obviously devise a cluster development plan, so for each of the 64 clusters across Wales, they have a cluster development plan, within which there should be ideas for service transformation as well as the sustainability of services for patients across their geographical footprint. How that is actually reviewed by the health board in terms of actually monitoring momentum and delivery against those action plans is variable, I would say, and it's not quite clear, so we need transparency around that.

[101] But you also need to triangulate that feedback against what's happening on the ground. So, from patients, have they seen a change in service provision? Have they seen the benefits of this with wider healthcare

professionals and access to social care to meet their needs? We need to triangulate with patient feedback, and we also need to triangulate it with practices and with our community team—so, our district nurses, our pharmacy and optometry providers—to look at where it's working well, why it's working well, and when it's not working well, why is that, what are the barriers, and what are the reasons, and address those. Because it seems to me that we have a national strategic policy that we're all signed up to, and we can see the benefit of it—there's lot of evidence to support working in this way from within the UK and outside of the UK—but that's not translating into real, transformative change on the ground level for patients, and that's what we're all here to do. They were designed to improve service delivery for patients. They were designed to provide sustainability for practices and to start that collaborative working wider than just at practice level. That's working very well in some places and not in others, and we need to work out why that is.

[102] I don't think there is enough scrutiny, enough transparency of how these plans are delivering, and where they're not delivering, why is that? We have a survey with a number of outcomes and a number of points from GP practices and from cluster leads, and it is disappointing to say that there's not been significant progress despite the significant additional resource that's been provided to these. I would also say that the evaluation of the pathfinder projects are those projects that were designed to transform and innovate across Wales—we haven't really seen the outcomes from that in terms of tangible change.

[103] **Angela Burns:** But who's responsible for doing that evaluation?

[104] **Dr Jones:** Well, I would say it's twofold. I would say it's Welsh Government because these are public funds, they should be scrutinised, and that scrutiny needs to be in a way that is clear and transparent, not just a form of a report—I don't think that helps us; it needs to be me measureable—and also from the health board and from the clusters themselves. So, we need to make them—. They need to be more transparent in terms of giving the outcomes that we would hope to see.

[105] I think that one of the key areas that we should be asking about is not just to look at the resource that's gone into clusters, but also look at the wider want of Welsh Government to transfer resource from secondary into primary care to deliver enhanced care in the primary community sector. There is a key performance indicator that I've been very keen to see brought

in for health boards about the percentage resource that has moved and the monetary resource that that equates to. Certainly, when we've asked this question before, we've only had evidence of one pathway being transferred into the community with moneys, and when we explored that further, it turned out it wasn't secondary care money, this was charitable money for a service delivery. So, again, we need to see that, because that's not to say it's not happening, but it's not clear, it's not transparent, and we're all here to try and make the services better for the patient at the end of the day. My colleague Ian may well have something further to say, because he's part of a federation in Bridgend as well that is part of the transformative pathfinder work.

[106] **Angela Burns:** Okay, but can I just quickly ask, Charlotte, because I think I picked out that what you said was that the 10 per cent of the funds that has gone into clusters, obviously that needs to be monitored, but you're also saying that you're not seeing any monitoring of the 90 per cent that's being kept by LHBs in order to enhance and improve primary care delivery?

[107] **Dr Jones:** Exactly, and it's not to say that that monitoring isn't going on somewhere, but we're not seeing it, it's not transformative, and I think there is a sense out there that the cluster moneys themselves are not being enabled for use by the individual clusters, and the pathfinder moneys, the tangible change that they've brought, it's not clear—

[108] **Angela Burns:** Sorry, but can I just stop you there again, because of the evidence we've just received earlier? When you say they're not being enabled for use by clusters, the message that we'd received fairly loud and clear was that, across all health boards, if the clusters wanted to spend their money in a particular way, the health boards do not have the veto to say, 'No, they cannot do it.' Is that not what is happening on the ground?

[109] **Dr Jones:** Absolutely not. In some health board areas they are utilising that money for what the cluster has asked them for. In others not. There are other barriers to enabling change: for example, procurement of equipment to deliver a service; and, for example, recruiting staff, because at the minute the clusters are not legally autonomous entities and we need to change that. So, therefore, the moneys are held by the health board and the way in which they recruit to posts asked for by the clusters means that, actually, there can be significantly long delays in getting job descriptions, advertising them and putting someone in place.

11:30

[110] Of course, at the moment, there is no ability or allowance for the cluster moneys to be carried over year on year, which was our understanding from previously—if something was badged for a project and there was a delay in delivering that, for whatever reason it was, that it could still be kept by the health board to be used by the cluster, but that's not actually what we've seen in reality. I'm thinking specifically here of Hywel Dda, and we're very happy to give you evidence on that—

[111] **Angela Burns**: Can I just stop you there, because I know that Caroline is going ask a lot more questions on funding? So, I just want to translate that back though to the whole—. My concern is that in two years' time, we'll sit here and go, 'Oh, clusters, weren't they a good idea?' and we won't actually know how to evaluate them. That's what I'm really trying to get to grips with, because it's great to have a warm, fuzzy feeling—we're all very positive about it, we all think that this has got real potential—but what we actually need to know is: is there value for money? Have we monitored an improvement in outcomes? I want to know who is doing that. I'm trying to understand who is doing that. The previous people said that there was a set of qualitative research, I think, coming out of Bangor University. Has anybody heard of that one? No, okay, I didn't think so. To find out how they were working. What I really want to be able to walk away from this evidence session with is understanding whether this is being monitored. Because I hate the thought that we're not following the money to an outcome.

[112] **Dr Jones**: The problem is, because of the delays in getting that money to do what the clusters have identified as being needed to be done, that you cannot monitor it very easily at the moment. Practices are, through the ways in which we work, very fleet of foot. We're very agile. If we want to make a change, we can make it. If I decide today, come Monday, it's in place. For example, around the warfarin enhanced service, we've identified we want to do it, the practice is drawing up a project plan, it will be done, and it will be in place very quickly whereas, when we have to involve the health boards, either because the person supporting the clusters isn't a decision maker or because of the request that's being made, it's not always driven by the cluster. Sometimes, it's the health board agenda, and we need to be truly looking at what the barriers are and how we can change those to enable us then to monitor it properly and see where those moneys are going. My colleague Ian Harris, to my left, will probably be able to give some further comments on this.

[113] **Dr Harris:** Hopefully. I think we have to remember the environment when clusters were set up. They were very much set up on the hoof, in some respects. They weren't organic structures that developed because GP practices felt that they were necessary. They were centrally, not imposed, if you like, but developed, and, as a result, I don't think clusters are at that level of maturity where evaluation and analysis of their cluster initiatives are necessarily part of their daily workload.

[114] So, I think, very much, clusters are developing in that area. I've seen evidence of a few initiatives in my own cluster that have had an evaluation, and the results are largely qualitative. I think it's fair to say that the data are not fantastic. Where there are data, they support the fact that certainly there are some cluster initiatives that are valuable to some extent, but if you're looking at value for money, often they don't reduce GP workload as much as you'd like to think they would, and they cost significantly more than, maybe, employing another GP would.

[115] **Angela Burns:** Right. That's interesting.

[116] **Dr Harris:** So, in the current climate where workforce pressures are quite significant and trying to attract GPs into the profession is very difficult, using allied professionals is something we're having to do, and we're all on board with that. But where you are using allied professionals to save GP time, the results can be a little disappointing at times, I think. We're also not looking at a huge amount of resource in each cluster that's being devoted to reducing that workload in each GP practice, if you like.

[117] For instance, in my cluster, we have six practices and we have one full-time equivalent pharmacist who comes and does sessions in each practice. Now, if you share that resource out across all six practices, it doesn't amount to a huge amount of resource to offload us. If you're talking then actually—. You know, one sixth of a pharmacist maybe saves you one eighteenth or one twenty-fourth of a GP, then you're not looking at a huge dent in the workload pressures that we see every day with the cluster initiatives. So, I think we certainly need to have more robust evaluation of these initiatives and I think that should be something we should look at.

[118] **Dai Lloyd:** The RCGP view, Isolde.

[119] **Dr Shore-Nye:** I'd like to come in on this, in a way, with two roles. I

have to admit I'm actually cluster clinical lead in Blaenau Gwent east as well as being a GP in Abertillery. So, having the experience first hand—a lot of the issues I know you've probably talked about already—particularly regarding evaluation, it can be very difficult to quantitatively evaluate a project that is designed to maybe alleviate pressure on the GP workforce when, actually, we know that the demand out there is certainly far and above what we may be putting in place.

[120] Ian mentioned pharmacists. My cluster is a cluster of five practices, maybe soon to be four, and we have 0.8 of a pharmacist, which took me seven months to employ through the employment process and recruitment. During that time, that money was being accrued and, as Charlotte eloquently put across, I cannot carry that money forward. So, you end up with having to put money into projects that you can't either fully evaluate or maybe are difficult to evaluate because they have that fluffy feeling that you mention—you know, what's improving the quality of care may not be easy to evaluate quantitatively.

[121] **Dr Fenton-May:** Can I just say, I don't think anybody has put any money into actually producing evidence about care for the patient and whether that is improving or not improving, using potentially wider teams and cluster working? And it would be quite useful if we could have some sort of support for that kind of research thing that is about quality rather than the quantity, which maybe where the money goes, which is what the LHBs may be looking at.

[122] **Dr Jones:** Certainly, for this committee, one of the areas I've often thought might be worth exploring is the three-year health board plans. If they've got three-year health board plans—and, okay, they've got to audit at year end, but if something is badged, carried over, you know, you can make that allowance—why is that not the case for clusters? Because, actually, that would enable the sustainability of some of these initiatives. Where we know that, actually, although we might not have enough of the pharmacists, or we might not have enough of something, where we know that actually, when they're there, they are making a difference, why can't we expand that and look at what's stopping us from expanding that? And actually, our 'Responsive, safe and sustainable: urgent prescription for general practice' calls for a pharmacist in each practice, because we know they're such experts in medicines that they can make a significant difference to us, day to day. Having access to an occupational therapist for our frail elderly who are falling can make a significant difference, but it's not easy to access. Why isn't that?

So, there's other evidence that says, 'Actually, the clusters need this to support them as well', rather than the cluster having to say, 'Please could I have—?'

[123] **Angela Burns:** One last little question on this, if I may—

[124] **Dai Lloyd:** Short. You're really using up brownie points, Angela.

[125] **Angela Burns:** —which is: have you had, during the two years that this has been in existence, anybody write to you or inform you of a benchmark that you can measure yourself against? So, does anybody say to you, 'Wow, these couple of initiatives have gone incredibly well—hey, the rest of you, the rest of the 64, have a look at it'?

[126] **Dr Jones:** Not with respect to individual cluster plans, but there is lots of evidence out there for benchmarking the input that physiotherapists can bring, and that pharmacists can bring, particularly, because, probably, they've been working in these ways for longer. I think that evidence will come out, but until we're transparent about how the resource is flowing into the clusters to make the changes, I think we're a little way off that, personally.

[127] **Dai Lloyd:** Speaking of fleet of foot and agility, that's required in the management of the rest of this committee, now. Going on to Julie, now, with the next question.

[128] **Julie Morgan:** Thank you very much. I wanted to ask about the multidisciplinary teams and, obviously, you've covered that a bit in the responses already. You can see the advantages, but could you spell out, in a general way, what are the advantages and disadvantages of working in multidisciplinary teams?

[129] **Dr Harris:** I think there are certainly advantages to it. They bring a different approach—we can be sometimes a bit entrenched as GPs, so I think there are certain benefits to having allied professionals within your team. They've got different skill sets. We mentioned that maybe the pharmacists didn't save quite as much GP time as we were hoping they would in our cluster, but certainly, there's a definite feeling that the quality of the input they can give perhaps is maybe even slightly better than that I can give in a medicines review. So, you're looking to get the right person treating the right person in the right time, if you like. So, there are certainly advantages to that.

[130] There are significant barriers and disadvantages to it, though. Currently, the allied professionals within that team are employed by the health board. Now, you've heard about the delays and the barriers we've got to recruitment as a result and the lead-in time to getting those feet on the ground, if you like. There are also other indemnity issues and risk issues with practices allowing other professionals to look after their patients, if you like, without having that insurance cover, and that's something that hasn't really been bottomed out fully yet. A lot of the allied professionals have their own insurance but they don't necessarily dovetail with ours and, as a result, clusters and practices are taking on significant risk to themselves when they allow their allied professionals to deal with their patients, because they're still ultimately vicariously responsible.

[131] So, there are specific challenges, I think, around getting the numbers up, because I think, as we've said, there are small numbers of resource in every cluster and I think there has to come a time when, if there's a proof of concept that these multidisciplinary teams are aiding us and improving patient care, then there needs to be a little bit of bravery on a health board level to be able to make that entrenched and a normal part of practice life, if you like.

[132] I'm quite sure that if you look at where patients access healthcare, they access it through their GP and they access it through the emergency department. The various initiatives we have about trying to signpost patients to here, there and everywhere don't tend to work because we've got two very fantastic brands, if you like, in the Welsh NHS, which are general practice and casualty, for accessing healthcare. What we need to do is make sure that we design services that sit behind those front doors. There is a degree of resource locked within health boards, if you like. If you're talking about employing physiotherapists or employing pharmacists directly to manage patients in primary care, then there is a resource locked into those health boards that they could release to clusters, but that requires a degree of bravery and a bit of organisational gumption, if you like, and, at present, I don't think we're seeing an awful lot of that.

[133] **Julie Morgan:** Do you think that will happen?

[134] **Dr Harris:** That's a very good question. We've not seen any evidence of it to date. And I think the worry we have is that you'll have 60-odd clusters developing initiatives, which appear to be very valuable, but that innovation

never becomes reality on a grander scale. I'm not entirely sure that health boards have twigged that that's exactly what needs to happen and, you know, time will tell.

[135] **Julie Morgan:** You've mentioned a number of different allied professionals, I just wanted to ask about speech and language therapists. Are they involved in any of these teams?

[136] **Dr Jones:** They will be involved with the care home enhanced service and they have been in some health boards for some time. But, certainly, they'll be integral to the delivery of the new care home direct enhanced service, which will be all health boards across Wales, and they are very important. But, again, all of these allied healthcare professionals are under pressure themselves because there aren't adequate numbers of them.

[137] So, where we have multidisciplinary team working, it's great in principle, sometimes it works, sometimes it doesn't: we've only got to look at our palliative care patients in the community and the strains on the district nurse teams, the clinical nurse specialist teams—there is just no capacity for doing it maybe as holistically as they would like. The multidisciplinary team-working principles are absolutely right, but what we need, though, is the actual mass of professionals to deliver it to make it work. It fits with the prudent healthcare agenda but, again, I think a lot of these problems lie at health board levels, either in terms of releasing the staff, recruiting the staff, and actually wanting to make that change. It does often make us beg the question: we have all the right evidence, we have all the right principles, we have all the right strategies at a national level—there's lots of evidence outside of Wales supporting these national strategies—why is it failing at a health board level and why is it not working, and, actually, where are the blockages, and is that actually because there's been too much power devolved to health boards to deliver these national strategies and they're not delivering? It's a question I ask often. It's a question I don't always get the answer for—

[138] **Dai Lloyd:** You're not going to get it here, now, this morning [*Laughter*]. Lynne, you've got a related question here.

[139] **Lynne Neagle:** Yes. You've mentioned some of the challenges already, but are there any other challenges you want the committee to be aware of in terms of making the multidisciplinary teams work, and what do you think needs to happen to overcome those challenges?

11:45

[140] **Dr Fenton-May:** One of the issues is there aren't enough of those other health professionals there, and the biggest problem is that most of them are trained in secondary care and, actually, the transition into primary care can be really difficult. If you take a ward nurse, for example—we've had practice nurses for 30 years now—and put her into a GP practice, she needs to be completely retrained; she hasn't got the skills to manage the kind of things that a practice nurse would do. Also, working in a more isolated—although GPs work in teams, we're sitting very often doing one-to-ones with patients. So, the practice nurses or the physios are doing that. They haven't got a whole kind of team of people behind a screen that they can refer to if I've got a problem in the same way. So, you need to teach them how to interact in a one-to-one way with the patients. There aren't enough clinical pharmacists either to be employed. The ones that are working in practices are not all fit for the kind of work that is going on. So, there's an element of training. Surprisingly, if you want to pull all these services together, any multidisciplinary team needs time in order to talk, which is why you're actually taking—. If you employ somebody else to work in a practice, you're taking time away from the GP because they've got to have that communication time with that other health professional. If you're not careful, the patient becomes 20 different bits—you know, drugs, big toes, physio, backs, whatever—and you need somebody to provide that holistic pulling-together service for the patient, and I see that as the GP and the leader of the team, who is able to deal with all bits of the patient, from cradle to grave.

[141] **Dr Jones:** When we go back to the prudent healthcare principle of only doing what you should be doing and using the team approach, it all fits with that, but we don't have the numbers of professionals under that. So, we need to look at what resource is there in the health board—is it being used in the right way, is there a way that we can get more into the community separately through other recruitment measures, and also making sure that the educational frameworks and support that they need are in place as well, which, actually, are not for some elements of the workforce. So, we need to address that before they're likely to want to start moving into these community and primary care roles.

[142] **Dai Lloyd:** Ocê. I ddatblygu'r syniad yna, Rhun sydd nesaf.

Dai Lloyd: To develop that idea, Rhun is next.

[143] **Rhun ap Iorwerth:** Mae hynny yn sicr yn ein harwain ni ymlaen at gwpl o gwestiynau gennyf i ynglŷn â chynllunio gweithlu, sydd, fel rydym ni'n gwybod, yn un o'r problemau mwyaf sy'n wynebu yr NHS yng Nghymru. Mi fyddwn yn gwerthfawrogi eich sylwadau chi ymhellach, os liciwch chi, ynglŷn â phroblemau cynllunio gweithlu. Ond hefyd, mae yna ragdybiaeth bod y ffaith bod clystyrau yn annog rhannu staff, o bosib, ar draws ardaloedd eang neu ar draws disgyblaethau ynddo fo'i hun yn fodd i ymateb i her y gweithlu. A ydyw hynny yn realistig, ynteu a ydyw pethau ychydig bach yn fwy cymhleth na hynny?

Rhun ap Iorwerth: That certainly leads us on to the few questions that I have about workforce planning, which, as we know, is one of the major problems facing the NHS in Wales. I would appreciate hearing your comments with regard to problems with workforce planning. But also, there is an assumption that the fact that clusters encourage the sharing of staff, potentially, across a wide area or across disciplines in itself is a way of responding to the workforce challenge. Is that realistic, or are things slightly more complex than that?

[144] **Dr Harris:** Fe wnaf i ateb hynny achos fy mod yn siarad Cymraeg, so rwyf tamaid bach yn glouach na gweddill y panel. [*Chwerthin.*]

Dr Harris: I'll answer that because I speak Welsh, so I'm a little bit quicker than everyone else on the panel. [*Laughter.*]

[145] I won't answer it in Welsh, Rhun, because my Welsh isn't that good, but I do think that, at present, if you're looking at the degree of workforce that's there, sharing it across clusters is a bit of a pipe dream at present because there isn't probably enough resource to go within clusters, let alone across cluster boundaries. The idea is fine. Like I said, the critical mass isn't there at present. I think we heard, with Isolde earlier, around the agility and the ability of clusters to be set free to set their own agendas is still in question, I think, in a lot of places. There is certainly work being done around structures of clusters that would allow them, if you like, to take on management of their own workforce and budgets and these sorts of things, but I don't think any of those have been addressed fully yet because we have federations and Pacesetter projects that currently have lovely structures, but they don't seem to be able to do anything with that structure as yet. I think that's the concern we have: (a) there is a fixed resource around bringing people into clusters because you are moving the resource—moving the deck chairs around the Titanic, if you like. There are also finite levels of resource that the amount of cluster funding can offer you, which doesn't really fill the

gap in the workforce that's already within practices. We have areas of general practice within Wales at present that are becoming deserts almost, and I think that's a concern for us at the minute, in that I don't think clusters are going—.

[146] There's a cluster local to me, in Morgannwg local medical committee, that has really tried to develop initiatives that look at recruiting GPs into clusters to share the resource around practices where there are gaps. They view the fact that GPs are not working independently. If your neighbouring practice is in trouble, it's going to become your problem very shortly. Certainly, there have been attempts to address that workforce gap within clusters—the problem is that there isn't a workforce to fill the cluster gap, if you like. I think we're all battling for the same people to employ within that. I think having the clusters agile and autonomous enough to go and fish for those people would help, because having the health board as an extra layer of bureaucracy in there certainly doesn't seem to be fostering collaborative working and autonomy within clusters at present.

[147] **Rhun ap Iorwerth:** And that confirms, I think, what we fear: that you just feel that you're fishing around in a pool with a limited number of people. The key is getting more people into that pool that you can choose from. Are you confident that things are in track now that there seems to be a recognition, at last, that workforce planning and training is a real issue?

[148] **Dr Jones:** Certainly, the ministerial taskforce, and the fact that the Minister chairs that, has made a difference with respect to looking at general practice recruitment specifically, and the initiatives around paying for the examination for GP specialty trainees across Wales, and the additional moneys for those going into hard-to-recruit areas, is showing benefits this year in terms of increased applications for those areas, and to Wales. However, that said, we do need more training places, but it's a bit of a chicken and the egg: you can offer 1,000 places, but if you've only got a 150 candidates, you're not going to fill them. So, you're almost setting yourself up to fail with respect to that. But we should have some flexibility that, where we get more applicants for an area and they're good quality applicants, they should be allowed to take up a training place, or have the funding to support that.

[149] There are lots of initiatives that are going on around widening access to medicine, thinking about shortage specialties outside of just general practice, but it's not all about the GPs either. So, we need to, yes, have more

coming through, but they're not going to come into, essentially, bums on seats for some time. So, it's not going to solve the here and now. So, we need to be looking at what we can do with respect to retaining the workforce we have, which is a challenge, and also how can we have those other allied healthcare professionals supporting us whilst the other initiatives come through.

[150] I'm not sure that enough focus is being spent with our nursing colleagues, looking at what's happening within district nursing and the wider primary community teams; I'm not sure enough is happening around healthcare support workers to allow nurses to work to the top of their area of specialty and professionalism and be able to delegate downwards appropriately; I'm not sure enough is being done around that either. And, again, we've got very good ideas around where pharmacists may well make a difference; we haven't got enough of them coming through. So, it's a challenge, but we need to accept that, at the moment, we're in the perfect storm: that things are starting to make a difference for the longer term—but, actually, will there be a general practice and primary community care to deliver it effectively until then? We have to be realistic and say, 'Okay, that's great, carry on working along that line and we welcome all of that work', but we need to be also doing more now as to how we can retain our current staff across the workforce and enable more to come in now. I'm interested in the recruitment campaign to see how that is actually translated into people working in Wales.

[151] **Dr Shore-Nye:** I think my answer encompasses the question about the multidisciplinary team as well. In the cluster where I'm currently leading, we've seen a halving in GP numbers within the last two years. So, I really would welcome the opportunity to work more with the multidisciplinary team, but I don't have enough of that opportunity within my cluster to do that because—as Charlotte's just mentioned—yes, I would like another physiotherapist, a pharmacist, an occupational therapist, some mental health nurses, to come and work with me in my cluster, but that isn't within my remit or my opportunity. At the moment, the funding that I receive as part of the cluster moneys would in no way at all address the need to recruit those specialties, even if I could.

[152] **Rhun ap Iorwerth:** And we come back to a point raised earlier about you're not entities in yourselves that can build up a team; you're dependent on the health board to do that for you. That's something that could, if you were able as an entity to build up, you know, all those members of a

multidisciplinary team as employees of your own—that would help.

[153] **Dr Jones**: Certainly that was in our urgent prescription for general practice, our strategy document, which is now some two years old.

[154] **Dr Harris**: I think it depends what you think clusters are there for, really. Because if you think they're there to prove concepts and allow health boards then to make the major investment further down the line, then I think that's what they're kind of set up to do. They have very small budgets. It may be a large amount of money from the public purse across the piste, but, if you look at individual clusters, a couple of hundred thousand pounds doesn't buy you many boots on the ground to deliver workforce change and workload change for GPs day to day. If they're there to prove the concept and to innovate and show initiatives that, then, health boards can pick up and run with and put in place across the piste, then I think that's what they're currently set up to do. I don't think they're set up to be entities with huge budgets that can deliver a lot of input for patients with the budgets they have.

[155] **Rhun ap Iorwerth**: And that's really interesting. I think that's something that's come across clearly to us, that different people have different interpretations of what clusters are actually meant to do, and if, to me, as a layman, looking from the outside, what I'd like to see is clusters being greater than the sum of their parts—you see the entirety of the budgets of all those surgeries and other elements of primary care that are part of that cluster, and somehow they come together, and are able to pool resources—it doesn't work like that.

[156] **Dr Jones**: No. It was designed that you would get the practices working collaboratively and start looking at service provision across its geographical area and, in time, they would then take on community budgets, community staffing, but they haven't been enabled to do that, unfortunately.

[157] **Rhun ap Iorwerth**: Is that one of the big barriers?

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

[159] **Dai Lloyd**: Okay, moving on. Funding next. Caroline.

[160] **Caroline Jones**: Diolch, Chair. I'd like to ask you a couple of questions on funding, particularly with regard to the cluster development moneys,

because we've heard that the allocation process is unclear, and also that it's not targeted effectively, that it should go directly to clusters. Are these concerns justified, and how do you think, if they are, that the funding may be deployed more effectively in the future?

[161] **Dr Shore-Nye**: Do you want me to speak from personal experience, rather than from the royal college experience?

[162] **Dai Lloyd**: Any number of experiences you have, as long as you carry on.

[163] **Caroline Jones**: Whichever—whatever you want to say.

[164] **Dr Shore-Nye**: The opportunities I've had in my cluster are—. I have met with quite a few cluster leads, and what I have noticed is that the way funds are utilised within the cluster varies considerably within health boards, and it can almost vary within health boards, about how the cluster money is able to be spent. Going—. Oh, I've lost my train of thought about allocation of money. So, I—.

[165] **Dr Jones**: The allocations are known every year, and they've been known for the last few years. The actual ability to use it is difficult and, actually, our BMA survey that we've done recently, to both cluster leads and to individual GP practices, has shown that there is a difficulty in actually mobilising that resource into tangibly putting in place the service you want to deliver, and that's not just for recruiting people; it's actually for equipment to deliver a service. It's for seemingly quite trivial little things, but that's not translating into enablement to use the resource. And also, we've had feedback that, for some clusters and some practices, they feel that where the cluster, as I've already said, comes up with an idea, because that might not fit with the health board's idea of what should be done, that they're not enabled to use the resource. Does that bring you back?

[166] **Dr Shore-Nye**: Yes, thank you, Charlotte. Sorry, I completely lost my train of thought. I believe the original allocation letter doesn't state about innovation. So, what we find is we may have an idea, or an idea might come through my cluster, but it may not fit the idea of the original letter that was apparently outwith of some of the GMS things that we should be providing within our contract. So, we reach barriers where we might have an idea—. I'll give an example. I talked about flu when I was here before. We wanted to provide something different for flu in my cluster, but I was put up against a

barrier that that was something that the GP surgeries were already funded to provide. So, it wasn't something that we could do within the cluster, yet other clusters in different health boards were providing a similar service. So, there is variability, and it gets very frustrating when you try and share your ideas with different cluster leads and find that, actually, each health board is interpreting it slightly differently. It may work out to some advantage in some health boards and against other health boards, and it varies between them.

[167] **Dr Harris:** Don't underestimate the fact that there is not clear decision-making processes within clusters at times. Clusters are at different levels of maturity and organisational levels across the piste. Certainly, we've had Pacesetter moneys to set up a federation with a constitution, with a limited liability company behind it, with voting rights and all these sorts of things. But that federation isn't the cluster, and we can make decisions as a federation, but the cluster, which involves the wider health economy, doesn't always have to agree with that. We're almost sort of hoisted by our own petard a little bit by the decision-making process that we have internally. And then, when you then make a decision and it's bounced back to you by a health board, that's incredibly frustrating. We are such agile, innovative people as GPs, because we run our own businesses, that we've only got a certain degree of patience with these initiatives, I think, and the danger, if we don't see quick wins and meaningful change through clusters over the next year or two, is that GPs will disengage from that cluster process.

[168] There have been tangible benefits, I think, around how GPs interact with one another. It may well be that 10, 15 years ago, you didn't speak to your neighbour down the road. He was your competition, if you like. Now, that certainly has changed, and that's by necessity, given the workload pressures as well. So, I think the conversation within clusters has improved. The funding is not enough to deliver any meaningful change, even if we were set free, I think, but setting us free would help that.

12:00

[169] **Dai Lloyd:** We have got the Pen-Y-Bont Health federation coming in in a couple of weeks' time to give evidence. Have you got another question there, Caroline?

[170] **Caroline Jones:** Okay. It's just about the salaries. We have been told that the funding is limited, short term in nature and is largely tied up with

salaries—90 per cent is the percentage figure we've been given. Can you elaborate on this? Also, with regard to Angela's questions, Charlotte wanted to say something on Hywel Dda health board, to recap, and I wondered if you could tie it all in, please.

[171] **Dr Jones:** The issue about the Hywel Dda health board was around a transfer of resource from secondary to primary care, which didn't turn out to be secondary care resource—it turned out to be a charitable resource. That was a few years ago; I think I brought it to this committee then. The issue around salaries is a huge challenge. Not only do you have to go through the recruitment process, they have to be employed and then we have to add the indemnity on top and the other terms and conditions. Because the moneys aren't huge to each individual cluster, you can see how it can get taken up by one or two pharmacists or one physiotherapist, or something like that. But, if that is what the cluster needs and is determined it needs, that's great.

[172] The moneys have been recurring for four years, so they are not really short term. But the problem is that they are short term if they are not allowed to be carried over because they haven't been used. So, that's a difficulty. But, yes, we have to make sure that these moneys are used for sustainable change. It is no good having something in for a year—where you have got funding for a speech and language therapist to come and help you with your frail elderly for a year, but then, actually, after that they don't know. So, why would a healthcare professional leave a stable job to come to a cluster job if there's no stability of employment? It's a difficult conundrum to marry up.

[173] The issue about indemnity is one I can wax lyrical on forever, but you really don't want me to do that today. But there are issues in terms of indemnity for the individual and the risks to the practice around vicarious liability, and our BMA advice, largely written by myself, is clear on that. But that is again a constraint, or something that practices aren't aware that they are leaving themselves open to risk about. The other problem we've got around the cluster moneys isn't so much about it being tied up with salaries. But, if it's not used, or the health board suddenly say, 'Well, you can't do that with it', it then suddenly has to go into short termism, and then, you know, practices and clusters are struggling to think of what they can use. They don't want to lose it—'The health board won't say yes to this'—so they might invest in iPads for staff to do remote visiting or for educational purposes: things that, actually, I'm not sure deliver the transformative change I would want to see. Although the moneys are small, they're small enough to have fired a flame of enthusiasm among the practices and the staff involved in the

clusters. But, because they are not having any momentum of change, that enthusiasm is disappearing rapidly, I would say.

[174] **Dai Lloyd:** Ian?

[175] **Dr Harris:** The other thing to say is that, if a cluster sets up and employs two pharmacists and finds that it is fantastic, unless the funding to that cluster increases exponentially, there is no more innovation in that cluster because you're tied. There has to be a process whereby the innovation within a cluster becomes practice across the health economy, and I've not seen any evidence of health boards showing an appetite for that, let alone a mechanism for releasing it.

[176] **Dai Lloyd:** Good. Time is against us; we're down to the last two questions now, team. So, Jayne next, then Dawn.

[177] **Jayne Bryant:** I shall be brief, Chair. I'm very interested to have your views and perspective on how effective clusters are, generally, in tackling health inequalities and responding to population health needs.

[178] **Dr Jones:** Okay, well, I'm going to take this from my national perspective. I do all the cluster plans for my own practice, by the way, and take them to my colleagues to review. We have very good reports from the Public Health Wales Observatory. They give us individual statistics in our practice around, for example, chronic obstructive pulmonary disease, cardiac disease, and they benchmark us against other practices in the area and across Wales. They are actually publicised on the My Local Health Service website. At a cluster level, I know that we have interactions with Public Health Wales around some of the screening programmes—bowel screening, cervical screening, breast screening—and about the vaccinations and immunisations of your population, and having discussions around how you can improve uptake of that, which leads you into looking at your vulnerable and more hard-to-reach areas. How that has translated into meaningful change, though, from cluster reviews of this—I haven't seen any evidence to say that, actually, having that in a cluster report and a cluster discussion has led to a real change in uptake rate. I would argue that it's not always the responsibility of the cluster and the practices; I think it needs to be part of a wider scale piece of work to look at how we can harness social media for teenagers who might not access these services, and through to tv and advertising to enable uptake of all the screening services. I'm thinking back to what happened with cervical screening—it went up massively after a

celebrity sadly died from cervical cancer and now it's dropped back off. People don't like the idea of bowel screening, but, when you explain to them, they do understand it. So, it's not just the cluster responsibility, but there is a role for the clusters in terms of looking at how services can be improved in terms of uptake and are there any gaps in what people are thinking about. But I don't think it should be solely the responsibility of the clusters to look at that. And different clusters cover different types of areas, so the challenges are different.

[179] **Dr Shore-Nye:** I have to confess up here that I think I am cluster lead in the cluster with the worst uptake for flu vaccine and the worst uptake for bowel screening and the worst uptake for—well, I don't think we're worse for cervical screening or breast screening; I believe that's a different cluster. I think there may be a role in clusters for addressing health inequalities. I think the issue is wider than just within the cluster team. I also think that it may also reflect on the maturity of the cluster and the stability and the sustainability of the services—healthcare, social care and other care—within that cluster area. If you look at Blaenau Gwent East, for an example, we are massively struggling with general practice recruitment. We have difficulty with nursing recruitment, there is a high level of social deprivation, and all of that cannot be entirely addressed by cluster working. We can address certain issues. We can look at concerted efforts and how these are promoted within the area, but I think that the issue is, as you say, a wider issue. It is looking at other ways of empowering that local community, the citizens from the community and the population rather than just the cluster.

[180] **Dr Jones:** I think the clusters, through sharing information and sharing how they go about delivering certain services, have helped with health inequalities generally. But, again, if that's measurable or not, it's very difficult to say. The cluster plans, though, are available for viewing, so the quality of that discussion should be captured there, but, as I say, I think it's a more wide-scale issue for addressing in different ways. Of course, some of these hard-to-reach groups are very, very small in numbers, so you need a critical mass, and I think, again, that fits a more health board/national approach sometimes for some of them.

[181] **Dai Lloyd:** Okay, on the [*Inaudible*.] issue, Dawn.

[182] **Dawn Bowden:** Thank you. A simple question, and I think I probably know the answer given the evidence that you've given so far: do you think that there is a case for less health board involvement and more clinical

leadership directly from the clusters, going forward?

[183] **Dr Harris:** I'll answer that: yes [*Laughter.*]

[184] **Dawn Bowden:** I thought that would be a simple one.

[185] **Dr Jones:** It might be a unanimous 'yes' and 'yes'. And more resource—yes, yes, yes. And more—

[186] **Dawn Bowden:** But that point in terms of the resource, because there has to be a link, doesn't there, because the resource comes from the health board, so it can't be complete autonomy? There has to be some accountability, doesn't there?

[187] **Dr Jones:** Well, the resource could come—if they were legal entities set up, as we've previously suggested—direct to the clusters, and you might get more meaningful, measurable change if it were to come to those. And it might be an idea to pilot that in those clusters that are of a maturity where they wish to try just to prove the concept. We all know there are always unintended consequences of some of these actions and, sometimes, the solution becomes a problem in itself when you're putting it together, but I certainly think that we should now be at a stage where we know which are the mature clusters, and let's give it a shot. You know, we've got nothing to lose by it, have we?

[188] **Dr Fenton-May:** The evidence that we've had from talking to different clusters is that, very often, the agendas of the meetings are set by the LHB, and the GP bits of the agenda very often fall off the end because there is so much push from the LHB rather than from the GPs, who may have five different agendas from the five different practices. So, we need to work in a different way, and the maturity of the cluster enables that voice of the GP to be heard better.

[189] **Dr Jones:** I think we need to go back to basics and re-establish the knowledge and awareness of what the clusters are, because they're not just the GP practices. But actually raise that, as well, and get some enthusiasm and excitement about what they could deliver, because I think we're all under such pressure that it's very difficult to engage in that.

[190] We actually have done a survey—I'm afraid of just the practices, though—within the last month and we shall e-mail that through to the

committee if that's of help to you, because there are some useful free-text comments within that, which might, again, be food for thought.

[191] **Dawn Bowden:** Okay, thank you.

[192] **Dai Lloyd:** Diolch yn fawr. Mae'r amser ar ben, felly, diolch yn fawr iawn. Tystiolaeth arbennig y bore yma. Diolch yn fawr iawn i chi am eich presenoldeb. Diolch arbennig, felly, i Dr Charlotte Jones, Dr Ian Harris, Dr Isolde Shore-Nye a Dr Jane Fenton-May. Fel rŷch chi'n gwybod erbyn nawr, byddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma i wirio'r ffeithiau. Fedrwch chi ddim newid eich meddwl ynglŷn â gwahanol agweddau, ond o leiaf fedrwch chi wneud yn siŵr bod y ffeithiau yn gywir. Felly, gyda hynny o eiriau, diolch yn fawr iawn i chi am eich presenoldeb.

Dai Lloyd: Thank you very much. Our time is at an end, so thank you for your great evidence this morning. Thank you for your attendance, especially to Dr Charlotte Jones, Dr Ian Harris, Dr Isolde Shore-Nye and Dr Jane Fenton-May. As you know by now, you will receive a transcript of the meeting to check for factual accuracy. You can't change your minds about different aspects, but at least you can ensure that the facts are correct. So, thank you very much for your attendance.

12:10

Papurau i'w Nodi
Papers to Note

[193] **Dai Lloyd:** Eitem 4 i Aelodau yw'r papurau i'w nodi. Mae yna bum wahanol lythyr yn fanna os ydych chi eisiau codi rhywbeth, neu, yn absenoldeb hynny, fe wnawn ni symud ymlaen i eitem 5.

Dai Lloyd: Item 4 for Members, papers to note. There are five different letters there if there's anything you want to mention, otherwise we'll move on to item 5.

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

Cynnig: *Motion:*

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

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

Cynigiwyd y cynnig.
Motion moved.

[194] **Dai Lloyd**: Cynigiaf o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. A ydy pawb yn cytuno? Dyna ni. Awn ni i mewn i sesiwn breifat, felly. Diolch yn fawr.

Dai Lloyd: I move a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Are we all in agreement? Okay. Then, we'll go into private session. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:10.
The public part of the meeting ended at 12:10.