Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 19 Mawrth 2013
Tuesday, 19 March 2013

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Dr Sharon Blackford	Cadeirydd, Pwyllgor Meddygon Ymgynghorol Cymru Chair, Welsh Consultants Committee
Dr Ruth Hussey	Prif Swyddog Meddygol, yr Is-Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant, Llywodraeth Cymru Chief Medical Officer, Directorate of Health, Social Services and Children, Welsh Government
Dr Chris Jones	Dirprwy Prif Swyddog Meddygol, yr Is-Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant, Llywodraeth Cymru Deputy Chief Medical Officer, Directorate of Health, Social Services and Children, Welsh Government
Dr Trevor Pickersgill	Dirprwy Gadeirydd, Pwyllgor Meddygon Ymgynghorol Cymru Deputy Chair, Welsh Consultants Committee
David Sissling	Cyfarwyddwr Cyffredinol Iechyd, Gwasanaethau Cymdeithasol a Phlant, Llywodraeth Cymru Director General for Health, Social Services and Children, Welsh Government

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

Dan Collier	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Tom Jackson	Clerc Clerk

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

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good morning to you all and welcome to today's meeting of the Public Accounts Committee. In the event of an emergency, we should follow the advice of the ushers. The National Assembly for Wales is a bilingual institution, and people should feel free to contribute in either Welsh or English as they see fit. Headsets are available for translation and for sound amplification for those who require it. I encourage everybody to switch off their mobile phones and pagers, just in case they interfere with the broadcasting equipment. We have not received any apologies. I know that Aled and Jocelyn will be joining us later in the meeting; they are currently in the Business Committee, which must be running slightly over.

9.01 a.m.

Contract Meddygon Ymgynghorol yng Nghymru: Cynnydd o ran Sicrhau'r Manteision a Fwriadwyd—Tystiolaeth gan Lywodraeth Cymru
Consultant Contract in Wales: Progress with Securing the Intended Benefits—Evidence from the Welsh Government

[2] **Darren Millar:** We are taking evidence today from both the British Medical Association and the Welsh Government, starting with the Welsh Government. The Auditor General for Wales's report on this was published on 28 February, and after receiving a briefing from the auditor general and the Wales Audit Office staff on 5 March, we decided as a committee that we wanted to undertake a short inquiry into this particular matter. I am delighted that, at short notice, David Sissling, the director general of health, social services and children has been able to join the committee this morning, as well as Ruth Hussey, Chief Medical Officer for Wales. A warm welcome to you in particular, Ruth; I think that this is your first appearance before the Public Accounts Committee. I also welcome Chris Jones, an old hand, I think, at these sorts of committee inquires. I thank you for your attendance.

[3] I appreciate that we do not have a paper from you; that is understandable given the time frame, so I am going to give you three minutes if you want to say a few words about your response to the auditor general's report and then we will go into questions from committee members.

[4] **Mr Sissling:** Thank you, Chair. First, we should say how much we welcomed the report. We will be accepting all the recommendations within it. It has already been a contributor to helpful interactions. It has been discussed with medical directors and I will be discussing it this afternoon with chief executives. We think that it will give us a very important impetus in terms of the relationship between the national health service, consultants and indeed the challenges that face us now and in the future.

[5] While talking about the future, it is also important to go back to 10 or 12 years ago and remind ourselves of the context within which the consultant contract was renegotiated. It was a time of very significant challenge for the medical workforce, with high level of dissatisfaction and risk to recruitment and retention, and there was a need to respond to that. Vacancies were at a very high level and moving in the wrong direction. Hence the contract, which had three main goals: first, to improve recruitment and retention; secondly, to enhance the working environment for our most senior doctors; and, thirdly, to provide the base on which there could be a full participation of doctors, and consultants in the modernisation of services and in service change in terms of their own practice and more generally.

[6] The results, which I think come through in the report, show a good story in terms of recruitment and retention—8% to 9% vacancies are down to 2%, although we still know that there are some areas of particular challenge. On the working environment, I think that we would say that it has broadly improved. I was interested to see the statistic of a working week for consultants that is four hours shorter, on average. However, the area where most anxiety was raised by the report is the extent to which it has capitalised the full involvement of doctors in change processes. It particularly focuses, quite appropriately, on the job plans, which is something that we will pay particular attention to, although I would say that it is not the only means by which we can get doctors more firmly involved. There are also issues about developing clinical leadership, good information, good communication, good engagement and just generally enhancing the relationship between managers and clinicians.

[7] I will conclude by saying that, in looking ahead and accepting the recommendations, we are focusing on job planning and those broader areas, but also making sure that we can see those in the context of the dynamic and fast-changing healthcare environment. As we talk about things like integrated care, it causes us to think quite differently about the way that we cast consultant contributions in the future.

[8] **Darren Millar:** Thank you for those opening remarks. One of the other things that the report highlights is effectively the lack of scrutiny, shall we say, from the Welsh Government, certainly post 2006, after the audit office did a piece of work. What plans do you have to make sure that the rest of the benefits that you are trying to accrue as a Government will be delivered and how do you intend to scrutinise the full implementation and monitoring of those benefits?

[9] **Mr Sissling:** I will start and I will ask Dr Hussey and Dr Jones to supplement and support my answers. The Welsh Government's role is to set direction in line with ministerial policy decisions; to ensure—and this is an area that I think is particularly fertile—that there is an all-Wales approach in relevant areas rather than seven different variant themes; and, to seek assurance that appropriate progress is being made—and I will come back to how we seek assurance—and to support and intervene. So, it is not passive assurance; it is active assurance. For example, if there are any problems or variation from expectations, we will take necessary action with the body involved. That means that NHS bodies have direct responsibility for implementing and monitoring the contract to ensure that benefits are realised and to discharge that responsibility within their own organisational settings, but importantly, that will require them to work together, where appropriate. We are particularly focusing on the work of the NHS employers' unit, which acts on behalf of the NHS bodies to make sure that there are national standards, guidance, appropriate speciality information frameworks, which is one of the recommendations, and monitoring systems, and we will be involved with that work as necessary.

[10] Finally, to describe the architecture of the system, we will work closely with the relevant professional bodies and, in particular, the British Medical Association to make sure that we have its full engagement and input into all processes. It has already been discussed with medical directors and, this afternoon, it will be discussed with chief executives. We will be setting up work streams with the NHS and then we will be making sure that we see the right delivery of the outcomes that we want, in terms of maintaining the right kind of position on recruitment and retention, vacancies, and the working environment. Moreover, we are getting more focus on the job planning processes and on the consequential benefits in terms of a modernised changing service.

[11] **Darren Millar:** Does anyone want to add to that? I see that you do not. One of the other things, before we move on to other Members, that the report outlines is that there has been a 29% increase in average consultants' pay. Do you think that that represents good value for money? How does that compare to consultant pay averages in other parts of the UK? Is it

more attractive here or less so?

[12] **Mr Sissling:** Maybe my colleagues could answer that. I would suspect that it is not dissimilar to other parts of the UK in terms of the general picture, but I do not know if Ruth could expand on that.

[13] **Dr Hussey:** I cannot comment in detail on other parts of the UK, but there are significant differences in the contract in Wales. Each individual consultant's pay is made up of a number of different elements: it depends on the circumstances, the on-call arrangements and any extra responsibilities that they take on. It is difficult to generalise about the differences between the different countries. However, there is recognition that there are differences in the way in which the commitment award and the excellence award work and it secures earlier benefit, if you like, in terms of consultant pay. That seems to be a bit different and is recognised as being an interesting way that the Welsh contract works, compared to that used in other places.

[14] **Darren Millar:** However, in terms of comparisons with this 29% increase—I appreciate that you may not be able to directly match that, but the auditor general has done a useful table on the contract differences—it appears to be more attractive to be a consultant in Wales, to be honest, when you look at the table. Do you want to comment, Chris?

[15] **Dr Jones:** I think that David alluded to the circumstances at the time of the implementation of the contract. That was a time when there was definitely a feeling that consultant pay had fallen behind comparable professional groups. It was a time when there was a real risk that consultants may have left the NHS en masse. There was a lot of talk at the time about consultant groupings going off, setting up chambers and contracting their services back to the NHS. So, the contract provided something of a pay increase, but that probably, at the time, seemed appropriate. It has stabilised the consultant workforce. We can see now that those conversations about consultants leaving have gone and the vacancy rates have gone down. It has also provided a mechanism to increase the number of consultants, which is a good thing. It has been quite stabilising. I do not know the comparison directly with other parts of the UK, but my impression is that probably there are no huge differences. There are some small differences between the Welsh and English contracts. The Welsh contract in some ways looks a little bit more permissive, but I am not sure that would be enough to persuade someone to come to work in Wales on its own, rather than England. I think that it has stabilised the workforce at a time of difficulty.

[16] **Darren Millar:** Thank you for that.

[17] **Julie Morgan:** You have referred to job planning and, at the beginning of the consultant contract, there was a lot of emphasis on it, I wonder whether that has lapsed a bit. What action does the Welsh Government propose to take to ensure that local job planning arrangements are supported by updated all-Wales guidance?

[18] **Mr Sissling:** Our intention would be to establish a work stream with some urgency, which we will initiate in terms of setting the direction. However, we would make sure that the NHS is fully involved and that the NHS employers' unit and other relevant parties play a significant role. We would want that group to firstly make sure that the 2003 standards are updated and relevant to 2013 and beyond. We would want them to reflect on the consultant outcome indicator project, which existed for the period between 2005 and 2009, but for a range of reasons did not continue beyond that. However, we need to make sure that we have the right indicators, so that we can monitor it at individual and collective level areas of progress against modern changing practice. We will also, through that group, be looking at issues such as those consultants who are working particularly long hours to see if there is national guidance that we can provide for that. We would probably set up a task and finish

group in the first place to make sure that we have the standards and monitoring and information arrangements in place, so that we can explore issues about consultant productivity and effectiveness. We would then establish an arrangement for monitoring. That would be through two streams: directors of workforce who have a significant role to play, but also workforce involvement through the medical directors, with Ruth as chief medical officer and Chris as deputy chief medical officer, interacting with them. At the heart of this will be board level responsibility. That is an area where I will have a particular role, if there are significant issues emerging.

[19] **Julie Morgan:** You mentioned the consultants' long hours. I do not know if that is something that we are going on to later on. I wondered how you would set about tackling that. Is there evidence that excessively long hours are worked?

9.15 a.m.

[20] **Mr Sissling:** I think that there is; I think that the report highlights that. When I joined the Welsh NHS in 2009, as the chief executive of Abertawe Bro Morgannwg University Local Health Board, one of the pieces of work that we did was an analysis of all the working hours of consultants. There were clearly some that were too long in terms of what anyone would accept as reasonable. We took action to amend the job plans to begin to bring the end of that tail inwards. That is action that we expect all health boards to carry out. We may be able to provide some national guidance to enable that in terms of standards. To an extent, that is an issue that has to be taken locally. I suppose it is a reassurance that the job planning process is working well that such instances are being identified and appropriately managed between the individuals concerned and their clinical leaders and others involved in the due process.

[21] **Aled Roberts:** I symud ymlaen â'r cwestiwn hwnnw, mae tystiolaeth bod un ymhob chwech ymgynghorwr yn gweithio dros 46 awr yr wythnos. Y bwriad gwreiddiol oedd na fyddent yn gweithio mwy na 37.5 awr. O ran yr ad-drefnu sy'n cymryd lle ar hyn o bryd, a yw'n ofynnol ar y byrddau iechyd i ystyried mai dim ond 37.5 awr y dylai ymgynghorwyr weithio?

Aled Roberts: To proceed with that question, there is evidence that one in six consultants work over 46 hours a week. The original intention was that they would not work more than 37.5 hours. In terms of the reorganisation that is happening at present, is it a requirement on the health boards to take into account that consultants should be working only 37.5 hours?

[22] **Mr Sissling:** You are absolutely right. This is an important issue for us. The path developed was 37.5 core hours. There was an acceptance that 12 sessions, which would be an extension of that, would be reasonable, so it would extend beyond 37.5 hours. We are particularly concerned about the consultants who are working beyond the European working time directive. That is where we need to be impatient for change, irrespective of anything else that is happening. To us, it is an unreasonable expectation that a significant number of consultants are consistently working for those extended hours.

[23] **Aled Roberts:** Mae'r adroddiad yn argymell bod angen tua 47 swydd ychwanegol o fewn y gwasanaeth iechyd yng Nghymru os ydym yn anelu at 37.5 awr. Beth fyddai cost 47 ymgynghorydd ychwanegol yn y gwasanaeth iechyd?

Aled Roberts: The report recommends that we need about 47 additional consultant jobs within the NHS in Wales if we aim for 37.5 hours. What would be the cost implications of 47 additional consultants in the NHS in Wales?

[24] **Dr Jones:** That is the number of consultant posts that would, in theory, be created by amalgamating all the extra sessions over 10. The difficulty with doing that is that there would be certain costs in terms of productivity. When you form a new consultant job plan, three out

of 10 sessions are potentially for supporting professional activity time and not for direct clinical care time. There are also added costs when you employ a new consultant: there are secretarial costs and other support staff type costs. Most health boards and trusts have probably reached the view that having one or two extra sessions is a relatively cost-effective way of increasing clinical activity, because you just pay for the clinical session, you do not pay those associated costs. It would not necessarily make value-for-money sense to amalgamate all those sessions to get everybody down to 37.5 hours.

[25] **Mr Sissling:** There would be a cost to that, but there is also a cost to people working greatly extended hours. So, part of the strategy to reduce the dependency on extended hours would be to potentially increase the number of consultants employed, because that might be a much more cost-effective and satisfactory way to deliver that. One of the things that we will be seeking is plans developed by health boards that are playing particularly to the point that you are raising.

[26] **Aled Roberts:** On the reconfiguration plans, does the national clinical forum take a view as to whether the deployment of consultants in more than one hospital is the most robust methodology that the NHS in Wales could use, or the reconfiguration itself, or does it assume that the health board has already done that? Is there any checking at a national level that there is a proper use of consultants' resources in the reconfiguration?

[27] **Mr Sissling:** Yes. The national clinical forum will be there to offer advice to health boards on such matters, but in terms of our assurance, we are seeking assurance from health boards involved in service change that they are paying appropriate attention to all matters in relation to the broader clinical workforce, and that they have, in detail, thought through matters about how the doctors, nurses and others can be deployed in a way to align with new service models. So, we seek assurance from the health boards that there is consideration of that. Where it is appropriate, we will seek it across health board boundaries, because not everything neatly falls into health board boundaries, as you know.

[28] **Dr Jones:** I think that the national clinical forum, which acts as a sort of critical friend to the health boards as they work together, may well ask questions about whether a certain pattern of working is actually deliverable within the current resources. So, it may, for instance, have a question about consultants working on a regional basis across several hospitals where there is considerable travel time. Obviously, that will be factored into the contract. It would be a matter of what would be the impact then on direct clinical care delivery. The national clinical forum may well ask such questions as, 'Have you factored in travel times into these considerations?', but I think that it is that sort of level of critical challenge in a way.

[29] **Mike Hedges:** I return to the subject of job planning. Do all consultants have an up-to-date and regularly reviewed job plan?

[30] **Mr Sissling:** The audit report states that the answer to that question is 'no'. They are not all reviewed on an annual basis. So, clearly, that is a matter to which the health boards need to pay attention, and we need to make sure that they are doing what they need to do.

[31] **Mike Hedges:** When we get audit reports they are normally several months old. So, you have had an opportunity, since the audit report was created, to ensure that that had happened. You are telling me that you have not.

[32] **Mr Sissling:** No. We got the report less than a month ago. Since that point it has been raised with medical directors. I am raising it this afternoon with the chief executives. I will also raise the clear need for urgent action to ensure that any of the immediate deficiencies are addressed.

[33] **Mike Hedges:** While you had the report a month ago, the information was collected substantially before that. The NHS directors at each site should have known that when they were providing information, they were providing information that job planning had not been done. Was there no sense of urgency somewhere along the line, having discovered that it was a case of saying, 'Oh dear, we haven't done the job planning. Perhaps we should'?

[34] **Mr Sissling:** That is an issue that I will be raising with the chief executives this afternoon. As you can see from the report, every health board has its own individual report. So, you are quite right, they are aware of their current position. They will be able to assure, or otherwise, that they have taken immediate action to at least start the actions that need to be put in place, which would take some time to do to get through all of the consultations to make sure that job plans are in place.

[35] **Mike Hedges:** What is your reaction to the auditor general's findings that general managers are not always involved in job planning?

[36] **Mr Sissling:** I think that it is a very helpful recommendation. As I said, we are accepting all of the recommendations. It is clearly an area where we need the right balance of clinical leadership and general management leadership into job planning processes.

[37] **Mike Hedges:** I have no doubt that you will accept the recommendations, but are you going to implement them? There is a big difference in saying, 'We accept the recommendations. We think that the recommendations are right. We will now put it back in the filing cabinet, and we will get back to it'. Are you going to make sure that these are implemented?

[38] **Mr Sissling:** Yes. I am sorry; perhaps I should make that clear: acceptance means early, urgent implementation. Acceptance without action would be wasteful and futile. So, our acceptance in that area means, for example, that general managers will become appropriately involved in job planning and processes, as indicated or as recommended in the report.

[39] **Mike Hedges:** When would we expect that to have occurred?

[40] **Mr Sissling:** It will start virtually immediately. Why should we delay? Our intention will be to make sure that we can get those arrangements started straight away.

[41] **Mike Hedges:** Why would you delay it? You have delayed it a month since you received it. So, I do not know why you would delay it any further.

[42] **Mr Sissling:** As I said, I am meeting with the chief executives this afternoon, and we need to make sure that the clear message goes out to those in positions of leadership. So, we will be implementing it with immediate effect.

[43] **Mike Hedges:** Or a month after you have received the report.

[44] **Mr Sissling:** Yes.

[45] **Darren Millar:** You will be able to publish a timetable for this committee to digest at some point in the future, once you have got that plan. In terms of this management issue, if managers are to be involved in the development of job plans for every consultant, will there be a capacity issue in some of the larger health boards with lots of consultants? Is that potentially an issue?

[46] **Mr Sissling:** There could be, but it is probably time well spent rather than additional time, because the consequence of not spending that time could be a demand on their time in other settings, subsequently. As always, it is better if you go upstream and get it right. Where there may be issues is that some might need a degree of training in some of the skills that it involves, so that will be part of the programme of work that we will set out.

[47] **Dr Jones:** May I comment that, having worked in two different NHS delivery organisations in the last three or four years, I know that both of those organisations had a strong focus on consultant job planning? It would surprise me if there was any health board or trust that did not, as part of its workforce plans, have a significant piece and commitment about job planning. There is a wide awareness of the importance and value of job planning out there. It is slightly surprising that so few consultants reported that they were getting a job plan, and I wonder whether that is to do with the level of formality and structure associated with those interviews. They should be quite structured and they should include a consideration with the consultants of objectives to be met through clinical service delivery and SPA time. There is a level of formality that, perhaps, is not always present. However, it is very much on the radar of all the health boards and trusts already. So, this is ongoing work, and it is disappointing to see that so few consultants feel that they have had a formal job plan interview.

[48] **Gwyn R. Price:** Why did the Welsh Government let the £1.9 million consultant outcome indicator project run on for so long before cancelling it? What lessons have been learned from the project?

[49] **Mr Sissling:** I am not sure that I can answer that question fully. I can offer some initial views, and Chris, who was working in the NHS at that point, will supplement those. However, there is a need to learn, which is why we want to undertake an exercise that provides an opportunity to examine all details and to make sure that we have a base of learning and learned knowledge on which we can build into the future. The first thing to say is that the project seemed extremely well-intentioned and appropriate; there was an attempt to look at the various issues that related to definitions of good consultant practice and the development of indicators, and expertise was engaged to bring that to bear. The limitations seemed to have been in terms of the systems and the availability of relevant information. Our patient administration system did not provide appropriate, adequate information that was sufficiently detailed to allow it to get real traction with consultants, and the sense was of gradual detachment by consultants from the process. The information that they were getting did not seem to be as relevant as they would want for their clinical practice. After a period of four years, a decision was taken to discontinue it. Perhaps Dr Jones can offer some further—

[50] **Dr Jones:** I suspect that the answer is that attempts were being made to improve the quality of the data so that this was not wasted investment. I remember, as a consultant, receiving my Compass data, which were kind of meaningless, because I could not relate to them at all. They did not seem to describe any aspects that I could recognise in my practice. I know that there was a lot of effort going on with the organisation that produced these data and colleagues in the NHS to try to improve their quality, but I never saw the quality improve as a consultant. As can be seen in the report, the decision to stop this was a pragmatic decision, in the end; it was not really working, and we were still quite some distance away from useful information.

[51] **Gwyn R. Price:** The project was successful in certain areas, so why were the outcome indicators not kept and developed further?

[52] **Dr Jones:** I am not certain that I can answer that, because I do not think that I made that decision or was part of the process at the time. However, there may well have been a missed opportunity. Clearly, we need consultants to engage in conversations about their

objectives through clinical work and also through the other associated activities that they undertake. They should be measurable where possible. We should set outcomes that they should achieve with the job plan. It would be helpful to have some sort of all-Wales context to ensure some consistency around that, and I cannot really say why that work has not happened over the last year or two.

9.30 a.m.

[53] **Mr Sissling:** The intention is absolutely to explore that question and set up a very urgent, early piece of work to allow us to understand why that did not develop, in a way. As we know, at times things move to a point where they do not quite realise themselves, but there are options other than just discontinuing. It could be that they developed it, but the sense I have from the research that I have been able to do in the time available is that the credibility of the process had been somewhat eroded or diminished in the eyes of the consultants, and they were detaching themselves from it. Then the group that was set up to oversee it took a decision that it would not be practical to continue it, having invested significant amounts of money. I suppose a judgment had to be made about whether it was wise to continue that kind of investment. In terms of taking things forward, what we do not want to do is replicate the errors of that past, so it is important that we now take stock of that particular exercise in a self-critical way, and then build on that for the future. We would not want, in three years' time, to be in a similar position of investing in a project that does not realise its goals, as worthy as the general aims seemed to be.

[54] **Darren Millar:** What systems are there elsewhere in the UK for measuring the consultant outcomes and key performance indicators, as far as consultant productivity et cetera is concerned? Are there any other tools that might be available so that you do not have to reinvent the wheel?

[55] **Dr Hussey:** We can certainly draw on experience from other countries. Actually, there was a report out yesterday, which I have not had a chance to digest, about consultant contracts outside Wales, so there are things that we can look at to help guide us. The important issue as we move forward from here is to really try to build in a whole approach to measuring quality and couple that with the need to increase transparency of clinical quality, and link that again with changing patterns of service delivery, which means that we need to have a broad understanding of what kind of outcomes we are trying to capture here. Specialties will vary, and the way that we practise medicine is changing quite rapidly. It is not an outpatient model, or operations, that we want to measure. Increasingly, people are doing consultations over the phone, and there are all sorts of things that we are trying to measure, so it is quite complex territory. The core thing for us is to make sure that it links with what we want to achieve around improving patient safety and quality, and to use that as the focal point for why we want to have clarity about what comes from individual contracts.

[56] **Darren Millar:** Four years is a long time, is it not, before somebody presses the stop button on a project worth £1.9 million?

[57] **Mr Sissling:** I would agree, yes.

[58] **Aled Roberts:** There is a reference in the report to a firm called CHKS running the project, and being responsible for running a number of benchmarking projects within the Welsh NHS. Can you give us an idea of how many projects it has been responsible for, and whether others have been more successful than this one?

[59] **Mr Sissling:** I could not, but I would be very happy to supply that detail to the committee if that would be helpful. I would be very happy to do so.

[60] **Jocelyn Davies:** Perhaps we could have clarification, because what the report says is that each NHS trust entered a five-year agreement with CHKS for this benchmarking work. Did it run for five years, because the agreement with company was that long? Did it therefore run and run, even though best value was not being had from it? Perhaps you could provide confirmation on that.

[61] **Mr Sissling:** I would be very happy to do so. This is part of the review, and whether from 2005 to 2009 there was some sort of break point in the contract that was also a stimulant to take a decision about its continuation, because if, over a five-year period, it did not realise its goals, then clearly a decision had to be taken about the wisdom of further investment in that kind of arrangement. We would be very happy to provide that information.

[62] **Darren Millar:** It does raise questions about the procurement process if there was a contract for five years where it was quickly realised, according to the report, that this was going to be deficient and was going to fail, ultimately. It seems to me that in future there ought to be earlier get-out clauses for these sorts of pieces of work.

[63] **Mohammad Asghar:** What work is being done to identify fair and meaningful measures of consultant productivity?

[64] **Mr Sissling:** To build on the comments that the chief medical officer, Dr Hussey, made, we are increasingly concerned not just about productivity, which is incredibly important, but also matters about quality, safety and effectiveness. A traditional and narrow approach to productivity that might look at the number of attendances or the number of outpatients that are seen in a session and say that an increase is more productive, also needs to be aligned with an understanding of the patient experience and the outcomes associated with that. It is not just about a simple division of the number of patient interactions divided by time.

[65] At the moment, particularly in the context of our learning-lessons reflections on the Francis report on the Mid Staffordshire NHS Foundation Trust, we are looking more generally at how we describe issues of quality, safety and productivity. That work is currently in train, and we will be working through it over the next two to three months to make sure that we have the right indicators. Some of those indicators will apply to consultants, but some of them—it is an important point in the report—will play to the wider clinical teams, teams of consultants, or teams of consultants working with other professionals.

[66] **Mohammad Asghar:** Has the Welsh Government had any discussions with the Office of National Statistics to see whether it can produce a Wales-only analysis of NHS productivity?

[67] **Mr Sissling:** Not to the best of my knowledge, but we would be very happy to look at that and advise you of the outcome of the discussion. The history of seeking a satisfactory measure of productivity in the NHS, in its most general sense, is variable in terms of trying to get measures that are satisfactory. However, the kind of discussion interaction that you have proposed is a very good one, and we will do that.

[68] **Darren Millar:** If there is a dataset out there, having it specifically for Wales is pretty important so that we can see whether any progress is being made. Have you finished, Oscar?

[69] **Mohammad Asghar:** To have an appointment with a consultant in Wales, there is a very long wait in various areas of the NHS. It is very difficult for people to get hold of a consultant. There are waits of 12 weeks to 21 weeks or six months, but, if you go private, you can see them the next day. That is the problem. Either you are not paying them enough or

they have extra work somewhere else, but we need consultants working for public health, which is what they are getting paid for.

[70] **Darren Millar:** Do you want to go on to ask about private practice, Oscar? I know that you have a question on that.

[71] **Mohammad Asghar:** I am concerned that consultants' productivity is not there for public service in Wales. There are a lot of anomalies there.

[72] **Darren Millar:** What attitude does the Welsh NHS take to private practice?

[73] **Mr Sissling:** The technical position is that consultants have to satisfy their contractual obligations to their employers, given that that is within the contractual arrangements. The position thereafter in terms of what a consultant or doctor does is not something that we would have a direct involvement in. Our main concern is that they are employed by the Welsh NHS bodies and that they fulfil their contractual obligations to Welsh bodies.

[74] **Darren Millar:** Is it not a matter of concern if people are working in private practice and also working 48 hours a week? How is that going to impact on the quality of care and clinical outcomes, et cetera? Is there any evidence to suggest that there is an impact, or is there no evidence? Is that something that you measure?

[75] **Dr Jones:** I am not aware of any such evidence, but I understand the point that you raise. The new approach to consultant appraisal to support revalidation may help that, because that is a whole-practice appraisal and requires doctors of all types to bring evidence about outcomes and quality from all aspects of their clinical practice to the one appraisal conversation. If someone was working in too many sectors doing too many hours and there was a concern about outcomes, it would become clear through that process. The appraisal discussions are not designed for that purpose, but, if something was apparent, that would be escalated. Our position is that we know that consultants have a right to do private practice; our concern is that they are effective and productive in the NHS and that that private practice never impacts negatively in any way on any aspect of NHS care.

[76] **Darren Miller:** Aled, do you want to come in?

[77] **Aled Roberts:** Os y gwasanaeth iechyd yw'r prif gyflogwr, a yw'n casglu gwybodaeth am oriau y mae ymgynghorwr yn eu gweithio yn y sector preifat yn ychwanegol i'r gofynion cytundebol arno yn y gwasanaeth iechyd?

Aled Roberts: If the health service is the main employer, does it collect data about the hours a consultant works in the private sector in addition to their contractual obligations under the health service?

[78] **Dr Jones:** No.

[79] **Aled Roberts:** Felly, os bydd rhywun yn gweithio 90 awr yr wythnos, yr unig wybodaeth yr ydych chi'n ei chasglu yw ei fod yn gweithio 47 awr yn y gwasanaeth iechyd, a'r unig amser y mae'r gwasanaeth iechyd yn ymyrryd yw os nad yw'r canlyniadau clinigol efallai yn effeithlon iawn.

Aled Roberts: So, if someone is working a 90-hour week, the only information that you collect is that they have worked 47 hours for the health service, and the only time the health service intervenes is if the clinical outcomes are perhaps not very efficient.

[80] **Dr Jones:** We certainly recognise that it is critical that every organisation in Wales

has a very sound clinical governance environment. This is an environment in which all aspects of any worker's performance and behaviour is recognised and dealt with as appropriate. If someone was clearly too tired, so that their behaviour was poor or they were somehow not concentrating or they were not working properly or whatever, we would expect all our organisations to realise that and to deal with it. We expect NHS care to be of the highest quality. So, we would expect organisations to assure themselves that that is the case.

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

[82] **Julie Morgan:** What view do you take on patients who are on NHS waiting lists but, because they are able to afford it, opt to see the consultant earlier and then come back to the NHS for an operation? Are there systems in place to monitor that sort of operation, which I have seen a bit of?

[83] **Mr Sissling:** There are procedures, guidance and rules that apply to those arrangements to make sure that there is equity in the system in terms of their position on waiting lists, for example.

[84] **Julie Morgan:** So, if somebody has seen a consultant privately, they do not have any quicker access to an operation on the NHS.

[85] **Mr Sissling:** It should not happen. The first thing is that it will be determined by their clinical needs, but, thereafter, there should not be any outcome that disadvantages anybody who has not taken advantage of that particular route.

[86] **Julie Morgan:** Right. You do not think that there is any evidence of that happening.

[87] **Mr Sissling:** Not that I am aware of.

[88] **Jenny Rathbone:** Is this not something that needs to be evaluated locally, because you are not going to be in a position to know whether somebody is jumping on the list at a higher place, are you? Are health boards alive to this problem and preventing it from happening, or is it something that is systematic and going on?

[89] **Mr Sissling:** I believe that they would be, but the prompt, obviously, is for us to take a bit of action just to make sure that the systems are clear and observed, which is what we will do.

[90] **Jocelyn Davies:** Just for clarification, if I go to my GP and he wants to refer me to orthopaedics, let us say, because that is an example that seems to be commonly used, and I ask, 'At this point, can I see that orthopaedic surgeon privately?', and the surgeon says that I need a knee replacement, would I not have saved at least six months, because I am going to be on the NHS waiting list for my knee replacement six months before I would have even seen that consultant to be evaluated? Are people evaluated in the private sector and then put on NHS waiting lists for the surgery? That is where the big timesaving happens, I am assuming, and I have cases that come to me, just the same as Julie Morgan does. Consider the pain clinic, for example: if you need to be seen by a specialist for pain and there is a six-month wait, if you can see that chap next week for £50, who is going to wait six months? I think that this is the point that Members are—

[91] **Mr Sissling:** It may help if we clarify the arrangements that are in place.

[92] **Jocelyn Davies:** I think that that would be useful.

9.45 a.m.

[93] **Darren Millar:** Oscar, did you want to come back in on that?

[94] **Mohammad Asghar:** I think I have asked the question, Chair, but I will ask it again: how are the NHS organisations receiving the necessary assurance that private practice commitments are not interfering with NHS commitments?

[95] **Mr Sissling:** Dr Jones set out some of the arrangements that we have in place. As I said, the main issue is that we receive from consultants the quality and the volume and degree of services that are under the contract. As the discussion previously described, the ability at the moment for us to understand in detail the level of private practice is limited. It would require arrangements that are not there at the moment. It relies therefore on us focusing on what somebody does while they are working for the NHS and an NHS body, and, if any concerns were raised about any conflict or any issues related to the impact of private work or, indeed, anything else that happens outside of people's attendance at work, they would be taken up on their merits.

[96] **Mohammad Asghar:** Do NHS bodies go about recouping costs from consultants who may be using NHS facilities to undertake private practice?

[97] **Mr Sissling:** Again, it may be helpful to respond to that one in detail. I would prefer to come back to you and give you a full written response to that.

[98] **Jocelyn Davies:** There is a system that has some transparency to it, however, so you would be able to tell if it was carried out at an NHS facility, but you would not have systems in place to track somebody if they were carrying out work in addition to their NHS work in their own facility, because obviously you would have to ask them to account for their time, and you do not have a system for that. Is that what you are telling us?

[99] **Mr Sissling:** You are absolutely right. If somebody is conducting private practice on NHS facilities, which is reasonably limited in terms of volume, obviously there would be greater knowledge of that, and there would be arrangements to make sure again that, financially, it was appropriate. However, the issue I think you are raising is somebody who undertakes their private practice in another setting in a private hospital. That is where the issue about the visibility of the level and the nature of it becomes one that has been the subject of discussion.

[100] **Dr Hussey:** I should emphasise the point that Dr Jones made before that the appraisal system does now require the individual to describe their whole practice, and that is quite a change in terms of how appraisal has developed. That will at least give an opportunity for the individual clinician to describe the whole of their clinical activity. That includes voluntary work as well as paid.

[101] **Darren Millar:** I have one final question on this area of private practice. Can you give an assurance to this committee that there are not consultants out there who are working for the NHS with whom the NHS is also contracting to deliver private operations or consultant episodes—whatever it might be—as part of waiting list initiatives et cetera, which would take them in excess of their 48 hours working-time directive week?

[102] **Mr Sissling:** I am not sure that I could give you that guarantee here and now, but I am very happy to ask that question of health boards and provide you with a response to that.

[103] **Darren Millar:** I think it is an important area.

[104] **Jenny Rathbone:** This is a problem we have been dancing around since the NHS

was founded in 1948, is it not? It is a very complex relationship. In any large business, the idea that one of your senior managers would say, 'I'm also going to be doing a bit of work for the opposition', would be completely unheard of and they would be firmly told that that was not on. I accept that we gave the consultants a large bag of money about 10 years ago in order to put a stop to the leakage of wholesale private practice, and it was effective in that regard, but I also recall one medical director saying to me, 'I'm being given a load more money and it's not going to change in any way what I do or make me work harder; I will continue to be the medical director at a very senior level.' What is disappointing is that during the intervening 10 years, we have not provided greater clarity on what we expect of our consultants in exchange for that very considerable remuneration—the lack of, in some cases, a contract on their duties, responsibilities and outcomes. That still does not seem to be mandatory and expected.

[105] So, I just wanted to focus on the importance of these supporting professional activities, because it is not just about ensuring that the consultant is not rude to the patient. It is unclear to me why, according to the auditor general's report, only two health boards have started working with consultants. They have linked SPA activity more explicitly to service objectives, and that is one of the things that David Sissling said that we want to do. So, I want some greater clarity on what the Welsh Government is doing to ensure that this is absolutely at the heart of what we are getting consultants to do, namely to discuss how they are going to effectively use their time to work smartly for our organisation: the NHS.

[106] **Mr Sissling:** You raise the SPAs and I suppose that the first thing we should do is acknowledge the vital importance of those parts of the consultants' work activity, namely those areas of research, education, clinical leadership audits and aspects of administration, which are absolutely critical, alongside the direct-patient-facing parts of their work.

[107] The answer to your question is that we see this as a priority. We will set out the requirements very clearly in the very near future and then we will ensure that there is detailed implementation work, to ensure that there is knowledge of the outcomes associated with those particular parts of the consultants' work contribution and that there is appropriate monitoring of those. In many cases, some incredibly valuable work is undertaken in those particular sessions, but we need to assure ourselves that that is a consistent picture across Wales, in every organisation for every doctor.

[108] **Jenny Rathbone:** How are you planning to link these SPAs with the General Medical Council's revalidation requirements, which I acknowledge are very important?

[109] **Dr Jones:** The revalidation recommendation is based on successfully completing annual appraisal, which requires the doctor to bring a lot of supporting information to the conversation. Generating that supporting information is the sort of work that will have to go on in SPA time. It is true that a doctor will have to spend a certain amount of SPA time each week simply to generate the outputs for the appraisal, but these are important outputs in terms of the quality and safety of the service as a whole. So, the consultant has to bring to the appraisal evidence of involvement in quality of improvement and evidence of reflection about serious events, as well as other evidence of all aspects of their practice. A lot of that is done within SPA time. So, we need SPA time to be able to enable consultants to fulfil the broad requirements to be revalidated.

[110] Equally, health boards very much need consultants to be undertaking the range of different activities—they need to be providing effective teaching and training, where appropriate, and research, where that is appropriate, as well as involvement in clinical audit, which is crucially important. So, all of those areas are really important for a health board and for a doctor as well. It is very much in their interest to ensure that SPA time is used effectively for those purposes.

[111] **Jenny Rathbone:** There is always a balance to be struck between the professional development of the individual and the clinical development of the specialty that that person is responsible for. How well equipped are the health boards to be able to navigate their way through that? I go back once again to the fact that only Aneurin Bevan Local Health Board and Cardiff and Vale University Local Health Board are actually linking SPA activity to the service plans required.

[112] **Dr Jones:** My belief is that all health boards are starting to do that work. There is an increasing appreciation that one needs to relate some managerial objectives to SPA time. It may not be so explicit, in project terms, in the other health boards, but that work is ongoing everywhere. What you describe is, in a way, the essence of the link between job planning and appraisal, although they are different entities. Clearly, it would not be appropriate for a consultant to come to an appraisal interview with an aspiration in their personal development plan that was unrelated to the expectations and needs of the service. So, the needs of the service have to be defined by the employer with the doctor in conversation during the job-planning interview. One would then expect what happens in the appraisal to reflect those needs. It is true that we need the job-planning interviews to be more structured, to be a process of setting objectives and to be a process of annual review against those objectives. A doctor's work needs to reflect the needs of the business and continually change to meet them.

[113] **Jenny Rathbone:** What is the Welsh Government doing to ensure that all health boards are up to speed on how to do what is, we can agree, quite complex? In one health board, consultants are working in three different ways—a practice left over from the board's previous life in a different health organisation.

[114] **Dr Jones:** I think that David has described the various mechanisms that the Welsh Government has that enable it to lead on change and improvement in the NHS. It happens through the medical directors, the workforce directors, the chief executives and, potentially, the work stream that David has also identified as now being necessary to respond to this report. We know that the health boards are very concerned that job planning is done to a very good standard. They are all very aware of that and are working actively on it.

[115] **Jocelyn Davies:** An intention of the contract was to address consultancy vacancy by introducing an incentive to work in Wales. We know from the report that there seems to be a speedier journey through the pay grades if you come to work as a new consultant in Wales, so there is a financial benefit, I suppose, at the beginning of your career in that you can progress more quickly. What data are available to you regarding recruitment and retention? Are you pretty confident that you have a very accurate picture of what is happening on the ground?

[116] **Mr Sissling:** We have enhanced data reporting over the course of the last 12 or 18 months to ensure that we understand the total number of vacancies at any point in time, the responsive action and the success rate in filling vacancies. We get regular reports from the service. You will be aware that there has been a particular focus on medical recruitment. At the moment, the vacancy rate is in the region of between 2% and 3%, which compares well with other parts of the NHS.

[117] **Jocelyn Davies:** However, that is new. This contract was put in place quite a long time ago, so in the last 12 to 18 months, I believe that you said, there has been an improvement in the data that the Welsh Government collects. You are now confident that you have an accurate picture, but what are you doing to ensure that these vacancies in Wales are as attractive as possible in certain specialities? I am thinking about vacancies for neonatal specialists in certain regions. If you have a shortage in a specific part of Wales, what is the Welsh Government doing to fill the vacancies?

[118] **Ms Sissling:** You will be aware that there has been a medical recruitment campaign, which seeks to promote the professional attractions of working in Wales and to promote Wales as a good place to build your career, and a good place in which to live.

[119] **Jocelyn Davies:** You are using that general campaign for medical recruitment; is that so?

[120] **Mr Sissling:** Yes. However, we are also aware that, in some specialisms—you raised a particular area, and I would add paediatrics and emergency medicine—there are particular UK-wide shortages of training-grade doctors. We are trying to do our best to counteract those shortages and ensure that Wales is seen as a good option. This applies not only to the focus of today's discussion, which is on consultants, but to the earliest stages of people's decisions to enter into medical education and to training-grade arrangements in terms of postgraduate education. The earlier that we can secure people's interest in Wales, the better. However, in some areas, as you know, we are working in quite constrained circumstances with regard to the availability of specialties.

[121] **Jocelyn Davies:** What is the strategy of the Welsh Government in those particular specialties that you mention, bearing in mind that there are shortages elsewhere in the UK in exactly the same specialties? What is the strategy to attract people to those specialities, over and above what you are doing in general to attract medical people to Wales?

10.00 a.m.

[122] **Mr Sissling:** The process that would be put in place—we have our general overarching campaign—is that, for particular speciality areas, we will be making particular strides to ensure, through the work of the health boards and more generally through the work of the deanery and at a national level, wherever possible, that we are explaining the benefits of coming to work in Wales and making sure that we have the right messages and the right educational opportunities. It is those kinds of areas and getting the right kind of professional environment that will attract people to come to Wales to pursue their career.

[123] **Jocelyn Davies:** Is there any information on the impact of the flexible working arrangements that arise from this amended contract in terms of attracting female consultants?

[124] **Mr Sissling:** I am not sure that we have that information today, but it is certainly an area that we could look at. We could provide information, over time, about the change in the gender mix of recruits in Wales, to see if we can get any information that is comparative that allows us to see whether that has been developed.

[125] **Jocelyn Davies:** Okay. Moving on to service modernisation and the relationship between managers and consultants, what is being done to build the best possible relationship between managers and consultants, bearing in mind how important consultants are going to be in terms of reconfigured services?

[126] **Mr Sissling:** I will start. There is some imminent work that I think is very relevant. The distinction between—

[127] **Darren Millar:** Sorry to interrupt, but can I ask everybody to be brief now, because the clock has beaten this part of the session? I ask everybody to be brief in the points that they want to make.

[128] **Mr Sissling:** First, we want to get more clinicians and doctors into positions of management—that is part of this—to make sure that we are not talking about doctors and managers in a way that polarises those communities. We must make sure that we have doctors

in clinical leadership. There is a major conference tomorrow, led by the chief medical officer, Ruth Hussey, to bring clinicians together to start exploring their role in leadership, to make sure that there is a line between their perspectives on the NHS and those of all other interested parties. We are also increasingly making sure that there is the right information to encourage the right kind of conversations between doctors and managers. We are doing work at a board level on managerial development, which is central. The issue is to make sure that our work, strategies and operational focus are credible and legitimate to clinicians as well as mangers. Currently, there is a review under way of our target regime, to make sure that that provides an opportunity to get clinicians fully involved. Targets are one of the things that can be divisive. Let us make sure that our targets speak to the clinical world and let us make sure that we use that to galvanise the right kind of relationships.

[129] **Aled Roberts:** Is your vacancy monitoring against medical establishment or against optimum staffing according to national guidance? If it is against establishment figures, given the point that you made on recruitment, does it surprise you that north Wales has only attempted to recruit to neonatal services twice in six years?

[130] **Mr Sissling:** The monitoring would tend to be against establishment, rather than other issues.

[131] **Jocelyn Davies:** That is how you collect it—

[132] **Mr Sissling:** Vacancies are an indication of the position against an establishment. There is, obviously, an issue about making sure that the establishments are appropriate at any point in time.

[133] **Darren Millar:** Okay. Thank you for that clarification. Oscar, you are next.

[134] **Mohammad Asghar:** My question has been asked.

[135] **Gwyn R. Price:** In light of the recommendations of the Review Body on Doctors' and Dentists' Remuneration, is the Welsh Government considering renegotiating the amended contract in Wales?

[136] **Mr Sissling:** At the moment, UK discussions are progressing and we are party to those. The specific policy position in Wales is something that the new Minister for Health and Social Services will take a view on.

[137] **Gwyn R. Price:** So you have to go back to Mark Drakeford. What you are saying, then, is that it is a 'no' on that. Why has it taken that view? Are you saying that it has all gone back to the Minister now?

[138] **Mr Sissling:** What I am saying is that, with a matter of this significance, it is a ministerial decision. While we are aware of, and party to, some of the discussions, it is clearly a matter that we would be expecting the Minister to take a decision on the future policy in this regard.

[139] **Darren Millar:** Thank you for that. That brings us to the end of this session. You will be sent a copy of the transcript of proceedings so that you can correct any inaccuracies. I remind you that you have promised to send us a timetable for the implementation of the recommendations, information relating to other NHS projects that CHKS would have been involved with, information in relation to NHS costs recoverable from private consultant sessions, information on the gender balance within the consultant workforce, and assurances over private sessions being purchased by the NHS with consultants who already work for the NHS. Thank you.

10.06 a.m.

Contract Meddygon Ymgynghorol yng Nghymru—Cynnydd o ran Sicrhau'r Manteision a Fwriadwyd: Tystiolaeth gan Gymdeithas Feddygol Prydain
Consultant Contract in Wales—Progress with Securing the Intended Benefits: Evidence from the British Medical Association

[140] **Darren Millar:** We will swiftly move on to the next item, continuing with our inquiry on the consultant contract in Wales. We are taking evidence this time from the British Medical Association. I am delighted to be able to welcome to the table Dr Sharon Blackford, chair of the Welsh consultants committee, and Dr Trevor Pickersgill, deputy chair of the Welsh consultants committee. Good morning to you. Thank you for attending our inquiry at such short notice. We appreciate your taking the time to be with us. I will allow you a few minutes to give the general position of the BMA in relation to this particular report, because there was insufficient time for anybody to be able to send in any written submissions. I do not know which one of you wants to lead on it; Sharon, do you want to start?

[141] **Dr Blackford:** Yes, I will start. Very briefly, BMA Wales welcomes the report from the Wales Audit Office and agrees with its findings and recommendations. From the BMA's point of view, we believe that effective, consistent job planning is vital in developing the potential of service improvements and modernisation of the health service, and we encourage our members to engage with job planning. However, all too often, as consultants working in the NHS in Wales, we find that job planning is simply a tick-box exercise where you sit down, agree on a timetable and clinics and then off you go, or, it is seen by our members as a way for the managers to reduce your SPA sessions and reduce the amount of money that they are going to pay you. It is the SPA sessions that seem to be under threat.

[142] Talking about objectives and outcomes is rare in most job planning meetings. In my job plan meeting with my managers, we spent about half an hour talking about my timetable, the clinics that I do and the number of patients seen and so on. In the end, I asked whether we were going to discuss outcomes and objectives, and I was met with blank faces, so I said, 'Thank you very much; I'll go then'.

[143] There is a lack of consistency in job planning within health boards and between health boards. Different directorates within a health board seem to take a very different approach to how job planning is conducted. A lot of that is due to a lack of training of the clinical directors and the middle managers. When the new contract came in, we had a programme of training, but most of the people trained at that time have moved on, retired or moved within the health board. Lots of new people have come in. In fact, middle managers change on a regular basis. The BMA has offered joint training at local health board level via the local negotiating committees and, on an all-Wales level, we have offered Welsh Government a national programme of joint job planning training for managers and consultants, which is what we should be doing. We should be working together, but it has not taken us up on that offer. We would hope that, as a result of today, we could move forward with a programme of joint training.

[144] **Darren Millar:** Thank you for those opening remarks; they were very telling. You suggested that the job planning process, as far as you are concerned, might be there simply to reduce the expenditure of the NHS on consultants. If that is the case, it has been pretty unsuccessful, has it not? There has been a 29% increase in average pay for consultants during the time that consultant contracts have been implemented.

[145] **Dr Blackford:** Obviously, at the beginning, there was a sharp increase and it has

levelled off in the last few years. Most consultants in the NHS are all working hard; they are busy and they are seeing lots of patients and working excessive hours. So, that is the thing about a time-sensitive contract. We did not have that before 2003, and most people were just on basic salary. People underestimated how much work we were doing and once we started measuring it, they had to start paying people for that work.

[146] **Darren Millar:** As a representative body, the BMA feels strongly that job planning is very important. What sort of action have you taken in addition to the development of guidance et cetera to encourage your members to request job planning on an annual basis, where it is not being given?

[147] **Dr Blackford:** Doctors are, perhaps, very good at knowing how to spend their time valuably, and if they see job planning being just a tick-box exercise, they will do it a few times and then think, 'What is the point? I could be doing a clinic, teaching my juniors or preparing a lecture for medical students.' That is the problem. We can encourage our members and we have run events—this week, we ran SPA development events, talking about job planning—but, after a few times of going to a meeting where you feel that there is no improvement in the service or in what you can do as a consultant, you are going to think, 'What is the point? I could be doing something better with my time than a pointless tick-box exercise.' That is the problem. If it was an effective thing, I think that consultants would be more positive about it.

[148] **Dr Pickersgill:** As Sharon said, we have a programme of events around Wales to promote good job planning and to show consultants what they can get out of it for their own development and the development of their service, rather than it being seen as this tick-box exercise. That was a couple of years ago. Since then, we have offered to do joint sessions with the NHS, as Sharon said, but that offer has not been taken up. However, we are doing things locally.

[149] **Darren Millar:** That is very disappointing.

[150] **Jocelyn Davies:** May I ask what the reason is—[*Inaudible.*]

[151] **Dr Pickersgill:** We have the JWCCC—the joint Welsh consultant contract committee—that was set up to negotiate the contract 10 years ago and that committee has not met since May 2012. It has been cancelled two or three times since then, principally because of the heavy and rapid turnover of officials in Cathays park.

[152] **Darren Millar:** Could you say that again? There is a committee, which last met—

[153] **Dr Blackford:** It is the joint Welsh consultant contract committee, which is supposed to meet regularly—we used to meet probably four times a year to discuss how the contract is developing. Obviously, it is not set in stone and things change, but we have not been able to organise a meeting with Welsh Government since May 2012. We have asked many times—

[154] **Darren Millar:** So, it does not show a sense of urgency or attach value to the job planning process.

[155] **Jocelyn Davies:** This is where—[*Inaudible.*]—and discussed; in that forum?

[156] **Dr Blackford:** Yes, in that forum.

[157] **Darren Millar:** Okay. That is something for us to take up. Julie is next.

[158] **Julie Morgan:** Trevor, you said that it was because of turnover in Welsh

Government officials that made it difficult to plan ahead. Has there been excessive turnover in terms of being able to plan?

[159] **Dr Pickersgill:** In the last 12 months, there has been almost 100% turnover in the officials whom the BMA deals with on a daily basis and who would, in effect, be on the negotiating team for the NHS. This committee that we have just described is the negotiating forum for consultants' terms of service, so, it is the contract and lots of other things, but principally, the contract. The negotiating team has changed completely, with the exception of Derek Jones.

[160] **Darren Millar:** That would be a very useful forum in terms of the full benefits of the contract being delivered.

[161] **Dr Pickersgill:** It always has been.

10.15 a.m.

[162] **Julie Morgan:** You have partly covered my next question. We have heard that, in England, the NHS Employers organisation and the BMA have recently worked together to produce a new guide to consultant job planning. Obviously, we have heard some of the reasons why this has not happened in Wales. Do you have any more reasons as to why this has not happened?

[163] **Dr Blackford:** Just to reiterate, we have offered several times and we have had those offers politely declined.

[164] **Julie Morgan:** So, what do you think that the Welsh Government should be doing in order to progress this?

[165] **Dr Blackford:** It needs to engage with the BMA, so that we can drive things forward. We do not need to reinvent the wheel. The job planning guidance that has been done in England is good and we can adapt that to the Welsh contract and perhaps organise some joint training, particularly for clinical directors. You do not have to pass an exam to be a clinical director; you just have to be keen. They are trained as consultants; they are not trained as managers. Often, they become clinical directors and think that they know what their contract is, but that is not always the case.

[166] **Julie Morgan:** So, do you feel that the Welsh Government is missing an opportunity to develop things?

[167] **Dr Blackford:** Yes, very much so.

[168] **Jenny Rathbone:** It is useful to know that clinical directors, above all, need training, because it is really important to have an understanding of how to get the best out of the individual in terms of the clinical outcomes for the patient. I am concerned that only Cardiff and Vale University Local Health Board and Aneurin Bevan Local Health Board actually link SPA activity to service objectives explicitly. I do not want to get hung up on SPAs, because outcomes and objectives seem very important too. I suppose that one of the things that I am concerned about is how frustrating it might be for a really dedicated clinician who sees the not particularly dedicated practice of a colleague not being addressed. If you are not having annual meetings or setting clear objectives, it is just a tick-box exercise. Where do the people go—those who want to raise the standard and improve the quality, which is what we are all about at this stage?

[169] **Dr Blackford:** Within my department, we have modernised, we have used specialist

nurses much more, we have cut down on the number of follow-up patients we see, and we write to patients with results rather than bringing them back unnecessarily. We have done all of that just off our own bat and no-one has really told us to do it. We have done it because we want to improve services for our patients.

[170] **Jenny Rathbone:** Absolutely.

[171] **Dr Blackford:** So, we have done that, but without the managers or anyone else being involved, because we are a small department and can do that. It must be much more difficult if you are a surgeon—I am a dermatologist and we are pretty self-contained—because you have to work with anaesthetists and intensivists and so forth. Clinicians do work together to drive forward change, but it is often done at a grass-roots level, without involving managers.

[172] **Jenny Rathbone:** However, it is extremely worrying if large organisations such as health boards cannot learn from the best practice that is contained within their own organisation.

[173] **Dr Blackford:** I agree.

[174] **Jenny Rathbone:** It is absolutely frustrating. There is clearly a major issue here that needs to be addressed.

[175] **Dr Blackford:** I agree.

[176] **Jenny Rathbone:** Is there any evidence that SPAs are meeting consultants' development and revalidation needs? Where is the best practice around using the SPA time effectively?

[177] **Dr Blackford:** In some departments, it is very effective. They have group job planning, if you like. They look at what needs to be delivered in an SPA, and this includes teaching and training of junior doctors. So, one person will take on the undergraduate teaching, another person will take on the educational supervision, and another person will take on clinical governance and audit. So, there are groups of clinicians doing that, but I would say that they are doing it among themselves more so than being led from above. Would that be your experience, Trevor?

[178] **Dr Pickersgill:** As you were saying, Jenny, in the previous question, it is variable even in a health board. From department to department, it is entirely dependent on the clinical leadership within those departments as to how effective the organisation of the workload and, therefore, job planning is. It very much depends on the individuals concerned.

[179] In answer to your question about a feeling that some people may not be pulling their weight, which I think is what you were hinting at, that is true in any walk of life, and, as intelligent professionals, most consultants will want their department to be the best and to try to build up quality, because that is the word that we must keep coming back to, especially given the Francis report over the last few weeks. They will want to try to mentor and encourage individuals, often younger individuals who may have less experience than their more senior colleagues. However, it is not all done through job planning; there is a lot of informal networking and helping each other out as well. Surgeons, for instance, will mentor each other in new operations, and younger surgeons may assist or work with more senior ones to make sure that their cutting skills are honed, even after the completion of training, because these are lifelong skills.

[180] **Jenny Rathbone:** So, if the clinical director does not have the leadership skills, it is very difficult to share good practice.

[181] **Dr Pickersgill:** This is really a big issue, in that clinical directors are often self-appointed or it is Buggins's turn and a case of, 'Oh, do I have to? Okay then, I'll do it for the next couple of years'. It is seen as the thing that you have to do eventually. It is just one of those things and you get paid a bit extra to do all this paperwork and stuff that you do not really want to do. It is not seen as professional or, by many people, as a development opportunity. It is seen more as something that must be done. Others, however, want to do it and they want to be leaders. Sometimes, those are the wrong people—they want to be the boss, but we do not need a boss; we need somebody who can bring a team together and who has good people skills.

[182] **Jenny Rathbone:** So, does anybody have a person specification for a clinical director?

[183] **Dr Pickersgill:** I am not sure that I have ever seen one.

[184] **Dr Blackford:** I have never applied, so I would not know.

[185] **Jenny Rathbone:** [*Inaudible.*]—work on, rather than—

[186] **Dr Blackford:** I am sure, and training for clinical directors—

[187] **Darren Millar:** However, that is something that you have offered specifically, namely training for clinical directors on job plans.

[188] **Dr Blackford:** We have offered joint training on job planning, the job planning process and setting objectives and outcomes and all that.

[189] **Mike Hedges:** If we are talking about the consultant outcome indicator project, I do not think that anyone has described it as the Welsh NHS's greatest achievement. I have two questions on it. First, what involvement did consultants have in the creation of this project? You identified serious problems with it very early on and no-one seems to have acted on that. Am I right that no-one acted on it, and do you know why they did not act on it?

[190] **Dr Blackford:** To answer the last question first, no, I do not know why they did not act on it. Perhaps they thought, 'Oh, it's just the BMA being its usual moany self' or something. We did warn them that this was not a good use of public money. We were not listened to for a while, but, eventually, we were proved right. However, I think that the problem was, to go back to the first point that you made, that clinicians were not involved from the beginning. The outcomes that were set for my speciality had nothing to do with what a dermatologist does day to day. We tried to invite CHKS to come along to a meeting of the Welsh dermatology forum, which is our specialist advisory group for dermatology, and we said, 'These are rubbish. Can we work with you?' We had one meeting and they were positive, but we never saw them again, so that did not fill us with confidence. If we were to do something like that again, the key is to have clinician involvement right from the word 'go'. Maybe it needs to be done at a more local level, rather than on a national level, because different areas will have different priorities. There are certain quality and patient satisfaction issues that are relevant across the board for every speciality, but, if you are a pathologist, it is quite different from being a neurologist.

[191] **Mike Hedges:** Without putting words in your mouth, do you believe that it is possible to undertake a task such as this without involving clinicians?

[192] **Dr Blackford:** No.

[193] **Darren Millar:** Are there any examples of decent models elsewhere in the UK that perhaps Wales could use or develop?

[194] **Dr Pickersgill:** I think that the temptation with the development of outcome indicators such as these is to do what the NHS has always wanted to do, and that is just count more beans, I am afraid.

[195] **Darren Millar:** Human beans.

[196] **Dr Pickersgill:** Human beans, indeed. I can see more and more patients in a fixed time in clinic, but, just like a GP in a busy practice, less time with each patient means less quality and satisfaction, and potentially poorer outcomes. So, the quality of service, rather than the quantity of widgets delivered, has got to be measured, and that is really hard. Nobody has got their head around that. There are very small pockets of sub-specialties where quality outcomes are measured, but even they are very un-robust—no, not un-robust, but insensitive—measures: for instance, very black-and-white things such as mortality after an operation for something or other. They are very fixed, but, in the greater scheme of the NHS, very small outcomes. They may be important for that particular patient, naturally.

[197] **Darren Millar:** There has to be some form of measuring of productivity, quality et cetera, however.

[198] **Dr Pickersgill:** I am not denying that.

[199] **Darren Millar:** No matter how crude they might be, people need these measures to be able to compare performance, do they not?

[200] **Dr Pickersgill:** They do, but the consultant outcome indicators project and the CHKS work were all based on statistics and modelling and numbers that were flawed from the word 'go'. We all know, on a day-to-day basis, that the numbers that we get given in our health boards are wrong. I have a patient right now who has been under my care for eight months, and he is shown as being under somebody else. He will never appear under my name, so how will that outcome be linked to me? It will not be. That is just a very stark example.

[201] **Darren Millar:** Jocelyn wants to come in.

[202] **Jocelyn Davies:** This is probably a very difficult thing to do, and the attempt in the past did not work out. We need clinicians. However, we do need to measure things. You mentioned the Francis report earlier; that started because of the measuring of mortality rates, and the comparison between hospitals, so it is important that we have information, and I am sure that you are not saying that we should not have this information, are you?

[203] **Dr Blackford:** The Royal College of Physicians ran a project that had an outshoot based in Swansea University looking at physician-y things. It was looking at this sort of thing, so it may be worth asking it.

[204] **Jocelyn Davies:** I guess that you would agree with me that there are certain things that are easy to measure—it is easy to measure the length of time that it takes from calling an ambulance to the ambulance arriving. It does not tell you whether the outcome was good, but some things are easy to measure, and that is what we are measuring and focusing on, but, of course, quality is something different, and we must surely, given that the health service has existed for so long, be working towards developing some indicators that would allow us to make comparisons and build on good practice.

[205] **Dr Blackford:** Of course, all doctors now, as part of revalidation, have to do what

they call 360-degree appraisal, which includes patient satisfaction outcomes—that is, surveys of patient satisfaction. Also, as part of our clinical work, as part of our SPA activity, we do regular clinical audit, which is often about quality, looking at what we are achieving. There is a lot of clinical audit and clinical governance activity going on within health boards that is about measuring quality, but that does not figure in any of these consultant outcome indicators. Those are just counting the numbers of patients whom you see, new to follow-up ratios, waiting times, and things such as that.

[206] **Gwyn R. Price:** Following on from that, you have covered a lot of it, but what can be done to identify a fair and meaningful measure of consultant productivity overall in your opinion?

[207] **Dr Blackford:** Again, it will be very different for different areas. The trouble is, you are saying 'consultant productivity' as if it is one thing, as if we all do the same work, and we all work very differently. Trevor and I are in outpatient-based specialities. For paediatricians, it is mainly acute work. For obstetricians, obviously, their work is completely different from what we do. The thing is to involve clinicians for each speciality, I think, and get them involved in it. Involve the BMA, the specialist groups and the royal colleges—that is where you have got us all together.

10.30 a.m.

[208] **Aled Roberts:** Rwyf eisiau gofyn fy nghwestiwn yn Gymraeg. Rwyf eisiau symud at oriau gwaith. Mae'r adroddiad yn nodi bod ymgynghorwyr yn barod iawn i weithio oriau ychwanegol os ydynt yn gweld bod hynny yn gwella cynhyrchiant, ac yn barod iawn i ymgymryd â swyddi rheoli ac ati. O'ch profiad chi, a oes pwysau ar ymgynghorwyr i weithio oriau hirach er mwyn iddynt wella eu gyrfaoedd?

Aled Roberts: I want to ask my question in Welsh. I want to move on to working hours. The report notes that consultants are very willing to work extra hours if they see that that improves productivity, and very willing to take up management posts, and so on. From your experience, is there pressure on consultants to work longer hours to improve their career prospects?

[209] **Dr Pickersgill:** Yes and no. Many consultants will be happy to work for longer hours. The contract is supposedly a 10-session contract with an average of 37.5 hours, but that ranges from anything between 36 hours and 42 hours in reality. Many consultants are happy to take on extra work, particularly to keep waiting times down, but also to improve care for emergency patients. Sharon said off the cuff that I am in an outpatient-based specialty, but I personally deal with patients with acute stroke in the middle of the night. We deal with ward referrals of patients with neurological problems admitted through A&E and via their GP, and that takes time out of those working-week sessions. Consultants are very willing to drive more and more to be involved in that type of work. I do not think that there is a lot of pressure to do more voluntary work, but many consultants work over and above their contracted hours to keep the service running and to do a quality job.

[210] **Aled Roberts:** Mae un o bob chwech o'r ymgynghorwyr a ddyfynnir yn yr adroddiad yn dweud eu bod yn gweithio mwy na 12.5 sesiwn yr wythnos. Mae hynny yn torri rheolau Ewropeaidd. A oes perygl bod hynny hefyd yn effeithio ar iechyd y cyhoedd?

Aled Roberts: One in six of the consultants quoted in the report say that they work more than 12.5 sessions a week. That contravenes European rules. Is there a risk that that could also have an impact on public health?

[211] **Dr Pickersgill:** I think that it is fair to say that the working time directive is there for a good reason, which is to protect the health and safety of workers. In the health services,

however, that clearly has a knock-on effect on the health and safety of patients. The BMA's position is that we support the working time directive and its full implementation for all health workers, whether they are trainee doctors, junior doctors or seniors. It is entirely up to the individual to opt out, and if I agree to a 13-session job plan, de facto, I have opted out of the working time directive.

[212] **Aled Roberts:** A ydyw yn benderfyniad i'r unigolyn yn unig? Roeddwn yn synnu clywed rheolwyr y gwasanaeth iechyd yn dweud yn gynharach y bore yma nad ydynt yn monitro'r oriau ychwanegol mae ymgynghorwyr yn eu gwneud o fewn y sector preifat. Nid oes ganddynt syniad faint o oriau sy'n cael eu gwneud yn y sector preifat—nid ydynt ond yn mesur yr oriau o fewn y gwasanaeth iechyd. Felly, sut mae'r gwasanaeth iechyd yn gwybod yn union nad yw'r ymgynghorydd hwnnw wedi gweithio rhyw 80 awr yr wythnos a bod hynny yn effeithio ar y cleifion hynny sydd o dan ofal rheolwyr y gwasanaeth iechyd?

Aled Roberts: Is it just a decision for the individual? I was surprised to hear the managers of the health service say earlier this morning that they do not monitor the extra hours that consultants do within the private sector. They have no idea how many hours are being done in the private sector—they only measure the hours within the health service. Therefore, how does the health service know exactly that that consultant is not working about 80 hours a week and that that is affecting those patients who are in the care of the health service managers?

[213] **Dr Pickersgill:** I suppose that the short answer is that they do not know, but the working time directive is specifically aimed at workers in an employee-employer relationship; it does not apply to self-employed work, which is what private practice is.

[214] **Aled Roberts:** It applies to the NHS, however, where the consultants are employed.

[215] **Dr Pickersgill:** Yes. That is the law.

[216] **Aled Roberts:** So, it is surprising that the NHS has no idea as to the additional hours that that person may be completing in a self-employed capacity, when in most other fields of work, an employer would insist that it knew how much work was being undertaken for another organisation.

[217] **Dr Pickersgill:** My feeling is that most consultants do not hide their private practice away. If asked about it in an open manner within their appraisal or job plan, they will share it. If there are issues of it impacting on NHS work, that is a matter of the health and safety of patients, productivity and whether they are breaching the terms of their contract. However, in the vast majority of cases, any private work is done outwith the contract. I do private clinics in uncontracted time; it is as simple as that. I am not contracted to work with the NHS. I can go home and play rugby with the kids and do the school run, or I can do something else of my choosing.

[218] **Darren Millar:** How many consultants would work for the NHS and then be contracted by the NHS to undertake private work? Is that something that is regular, as part of waiting time initiatives for example?

[219] **Dr Blackford:** Waiting list initiatives are usually carried out in the NHS.

[220] **Darren Millar:** But some are not, are they?

[221] **Dr Blackford:** Some are not. It is a very small proportion and it is usually in February and March every year.

[222] **Darren Millar:** So, of those ones that are going on right now, how many of those are being undertaken by NHS consultants who are contracted by the NHS as private consultants to undertake additional work in order to clear the waiting lists?

[223] **Dr Blackford:** They are probably being paid waiting list initiative rates rather than private rates.

[224] **Jocelyn Davies:** It does not matter how much; it is the time. This is not jealousy about money; this is about time.

[225] **Dr Pickersgill:** That practice that you describe is very much less prevalent than it used to be, when it was a matter of policy that the Welsh Government would pay the private sector to clear the waiting lists. That policy was reversed a few years ago, if memory serves me right, but there is a bit of it going on now. However, they are very small numbers. I have no figures on how many consultants do that kind of work. I suspect that the vast majority are orthopaedic surgeons, and I also suspect that the vast majority doing that kind of work will be doing it in the time that they were doing private practice anyway. In effect, it is their private practice, but instead of an insurer or a patient paying, it is the NHS.

[226] **Darren Millar:** The issue here though is that, on the one hand, we have just had the director general of the NHS saying that we have to get people's working hours down to 48 hours, which could then have an impact on waiting times, and then, on the other hand, the waiting list initiative will start and the same people for whom he has got the hours down will potentially be contracted to deliver additional hours in their private practice. The answer that you are giving us is that it does go on, but you do not know to what extent.

[227] **Dr Blackford:** I think that it is a very small amount. It is in probably two specialities—plastic surgery and orthopaedics, I suspect—and it happens in January, February and March, up until 1 April usually, and then, during the rest of the year, it does not happen.

[228] **Jocelyn Davies:** There would be a way, in those cases, of the NHS knowing that it contracts that person for this amount of time, and that it is also paying them for doing that chunk of time, even if it is only for those three months of the year.

[229] **Dr Blackford:** The only way that the individual would do it would be by taking annual leave and doing it during their annual leave or in their uncontracted time; it would not be done in contracted time.

[230] **Jocelyn Davies:** So, it is time.

[231] **Jenny Rathbone:** I just want to pick up on something that was mentioned earlier, which is the time that some consultants give to out-of-hours consultations in emergency situations. Obviously, it does not apply to dermatology—

[232] **Dr Blackford:** In the case of acute stroke—

[233] **Jenny Rathbone:** It might do, I apologise; I am not a dermatologist.

[234] **Dr Blackford:** I do go in at weekends.

[235] **Jenny Rathbone:** What I mean is that there is a desire in unpredictable services, like obstetrics, to have a seven-day week, 24-hour rota. How realistic is that in the context of the not very clear arrangements around what hours—

[236] **Dr Blackford:** There is nothing in the contract that would preclude that happening.

However, if you are working evenings and weekends, and you are still sticking to a 12-session limit, then obviously you are going to be doing less work Monday to Friday, 9 a.m. to 5 p.m.. So, it will either shift work to out-of-hours, and if that is elective work, that is stupid, because it is much safer to do elective work Monday to Friday, 9 a.m. to 5 p.m.—it has better outcomes; all the evidence shows that—or you will need more people to do the work. So, it is not cheap. You are going to need more people to still do the routine work and, if you are going to have more consultants, that is the trouble. It is not—

[237] **Jenny Rathbone:** There are other factors like critical mass and reconfiguration in order to get—

[238] **Darren Millar:** I just wish to remind Members that I am conscious of the time and we need to move on. Oscar, you have a very brief question on private practice.

[239] **Mohammad Asghar:** Most of my question has been answered. However, Dr Trevor said that there is an employee and self-employed element there, but surely they are working for the NHS and public health is a top priority. That is the law; that is us talking within the law. We are not here for personal greed, but they are making money here. Consultants are playing God in certain areas, but they are very hard to come by. Is there any feasibility to having a 24/7 consultant service in the NHS?

[240] **Dr Pickersgill:** Do you mean a 24/7 consultant-delivered service?

[241] **Mohammad Asghar:** Yes.

[242] **Dr Pickersgill:** The BMA supports a consultant-based service leading into a consultant-delivered service for patients. There are 168 hours in a week and if you want consultants to be present for all of those 168 hours in any single speciality, you will have to treble or quadruple the number of consultants. That is an issue for budgeting and availability and recruitment and all of those things.

[243] **Dr Blackford:** Also, having them present if there is nothing for them to do might not be very sensible.

[244] **Dr Pickersgill:** Or efficient.

[245] **Dr Blackford:** Or an efficient way of running a service.

[246] **Jocelyn Davies:** I do not know if you heard the earlier evidence, but the Welsh Government feels that it now has accurate data on vacancies and retention. I do not think that you agree.

[247] **Dr Blackford:** No.

[248] **Jocelyn Davies:** No, I did not think that you did and I was not all that convinced by the answers that we got earlier. You obviously feel that there are insufficient data, but what can be done to make sure that posts in Wales are as attractive as possible, especially in those specialities where we know there are shortages? I know that a few were mentioned earlier and my friend here is bound to mention neonatal services in north Wales, but what about A&E and paediatrics and others?

[249] **Dr Blackford:** I heard David Sissling say that there are national shortages in some specialities and that is obviously very difficult to tackle. When there is a national shortage of A&E doctors, how are we going to attract them to Wales? I honestly think that the Welsh contract is an attractive one for doctors. You asked him about the report of the Review Body

on Doctors' and Dentists' Remuneration and whether they would be renegotiating it. The BMA Wales's position is that health is a devolved issue and that we negotiated the amended contract with the Welsh Government and implemented it in 2003. We feel very strongly that we should stick with a Welsh contract and not return to a UK position because that is a way of attracting people to come to work in Wales. The other thing that may attract people to come to work in Wales is the changes in the healthcare system in England. Those may actually be the best recruitment drive, when you consider the foundation trusts et cetera.

[250] **Jocelyn Davies:** I also want to ask you about the impact of the flexible working arrangements and whether they have encouraged women—

[251] **Dr Blackford:** Certainly, on a trainee level, the deanery has won awards for being the most family-friendly deanery in the UK. I was a flexible trainee for a while and I worked part time as a trainee and then as a consultant for the first two years. I returned full time when my children went to school. That flexibility encourages people to stay in the workforce. They may not work part time forever. Like me, they might want to be part time for a few years and then increase their hours. The other thing is that many of my colleagues in Singleton Hospital, where I work, have retired and returned, so they came off the on-call rota as physicians, but have come back to work for four days a week to do out-patient work. So, they have dropped off from doing the acute stuff. They might have retired a few years ago at 60 or 62, because it is a grind being up in the night when you are that old, but allowing this retire-and-return scheme has kept valuable and experienced people in the workforce who might otherwise have been lost.

[252] **Jocelyn Davies:** Following what I have heard today, would you say that long hours are a badge of honour within your profession? I am not talking about dermatologists, but across the board.

[253] **Dr Blackford:** Not with dermatologists, no.

10.45 a.m.

[254] **Jocelyn Davies:** Are long hours a badge of honour? That is what I am hearing today.

[255] **Dr Blackford:** There is a bit of a macho culture in some specialities.

[256] **Dr Pickersgill:** Saying that it is a badge of honour is a slight exaggeration, but there is an element of truth in it. One issue that you will hear about from surgeons in particular is that you cannot train a consultant in 48 hours—it is just not possible. If training is improved and more consultants are present to do the teaching on a labour ward, for instance, when junior doctors are delivering babies and doing caesarean sections et cetera, they get much better training. Our position is that you can train a doctor in 48 hours; it is entirely possible. There is a bit of a macho culture. You could say the same about many top-level professions.

[257] **Dr Blackford:** We are a very competitive group of people.

[258] **Darren Millar:** We have two more questions, and I will allow Members to ask them; however, I ask for brief answers in response.

[259] **Julie Morgan:** It has been suggested that the reforms in England might result in more doctors coming to Wales; is there evidence of that yet?

[260] **Dr Blackford:** Not yet, but it might happen—fingers crossed.

[261] **Julie Morgan:** Does the BMA think that there would be any value in reintroducing

an annual reporting mechanism involving local negotiating committees to help to get assurance that the intended benefits of the contract are being realised?

[262] **Dr Blackford:** As the chair of an LNC, I was involved in looking at this issue. I have to say that I did not always believe the reports.

[263] **Darren Millar:** So, the reports would have to be more robust.

[264] **Dr Blackford:** Yes; they would have to be robust reports.

[265] **Dr Pickersgill:** There should be reporting mechanisms now—I think that you alluded to this earlier—as to the number of consultants in each health board with appropriate job plans. We would question the quality and robustness of those job plans, but those are the reporting mechanisms that are in place; I think that they need to be strengthened.

[266] **Aled Roberts:** I think that you have answered my question on the renegotiation of the contract. I take it from your earlier response that you would not favour a move away from the all-Wales contract; is that so?

[267] **Dr Pickersgill:** The BMA's perspective is very clear: what is going on in London is an England and Northern Ireland negotiation; Scotland and Wales are not part of that. Welsh Government officials, as you heard from David Sissling earlier, are sending observers. I think that that is the current state of play. If the Welsh Government thinks that there is a problem with the Welsh consultant contract, it needs to come to talk to BMA Cymru Wales and not a negotiating team in London.

[268] **Dr Blackford:** We are happy to negotiate with the joint Welsh consultant contract committee.

[269] **Aled Roberts:** Given what we heard about the JWCCC, it has not come to you to say that its view is that there is a problem with the contract.

[270] **Dr Pickersgill:** It has not come to us to say that there is a problem that needs to be fixed. If there is a problem, we would be very happy to discuss it.

[271] **Darren Millar:** On that note, we come to the end of this particular session. I thank you, Dr Blackford and Dr Pickersgill, for your attendance; we are very grateful. You will be sent a copy of the transcript of today's proceedings. If there are any inaccuracies, please feel free to contact the clerks and we will address them.

10.48 a.m.

Papurau i'w Nodi
Papers to Note

[272] **Darren Millar:** We have a paper to note, which is in respect of our report on civil emergencies in Wales. I take it that the paper is noted.

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

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

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

[274] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.49 a.m.
The public part of the meeting ended at 10.49 a.m.