Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 19 Tachwedd 2013
Tuesday, 19 November 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
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr David Bailey	Dirprwy Gadeirydd BMA, GPC Cymru Deputy Chair BMA, GPC Wales
Dr Charlotte Jones	Cadeirydd BMA, GPC Cymru Chair, BMA, GPC Wales
Mr Dave Thomas	Swyfddfa Archwilio Cymru Wales Audit Office
Mr Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

Fay Buckle	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 08:59.
The meeting began at 08:59.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everyone, and welcome to today's meeting of the Public Accounts Committee. The meeting, of course, is bilingual, as is the National Assembly for Wales. So, there are headsets available for translation for those who require them. These can also be used for sound amplification. I encourage Members and witnesses to switch off their mobile phones and any other electronic equipment because they can interfere with the broadcasting equipment. In the event of a fire alarm sounding we should follow the instructions of the ushers and, hopefully, we will get out safely.

[2] We have received apologies today from Dr Andrew Goodall, who was scheduled to

appear before the committee today to give some evidence to us on our unscheduled care inquiry. Unfortunately, he is not available to be with us, so we have had to reschedule his evidence session for 16 January. However, I am delighted that we have other witnesses who were able to attend today. We will therefore move straight on to the second item on the agenda to take evidence from the British Medical Association in Wales.

09:00

Gofal Heb ei Drefnu: Sesiwn Dystiolaeth 1
Unscheduled Care: Evidence Session 1

[3] **Darren Millar:** I am very pleased to be able to welcome to the committee Dr Charlotte Jones, Chair of the British Medical Association General Practitioners Committee Wales, and Dr David Bailey, deputy chair of BMA, GPC Wales. Dr Jones, I understand, is a general practitioner in Swansea.

[4] **Dr Jones:** I am indeed. That is exactly right.

[5] **Darren Millar:** Dr Jones is the chair of the General Practitioners Committee and you were critical, I believe, of the Wales Audit Office report, saying that it did not describe the workload issues facing GPs in normal working hours, and that GPs have little or no spare capacity. We will ask you to expand on that in a few moments.

[6] Dr Bailey is the deputy or vice-chair of the same committee. I understand that you were also critical of the WAO report.

[7] **Dr Bailey:** Indeed.

[8] **Darren Millar:** The committee members have obviously seen the evidence that you sent to us, for which we are very grateful. Would you like to make some opening remarks, and then we will move to some questions?

[9] **Dr Jones:** I think that we always welcome any Wales Audit Office report into services, but I think that we have to be aware that there are often gaps, whether those are gaps through misunderstandings or because it just simply has not felt that there is enough evidence or commentary to put into the report. In terms of the general practice element within unscheduled care, we feel that an enormous amount of work goes on within general practice across the 24/7 period, and we do not think that that has been captured adequately within this report.

[10] **Darren Millar:** Okay. We are very grateful for that. Obviously, the report touches on many different aspects of unscheduled care, and the committee has decided that it wants to focus particularly on access to primary care, those people who are return visitors to accident and emergency departments, and the future possibility of a 111 service in Wales. If the analysis in the WAO report is not right, what do you think is causing the big pressures on unscheduled care in Wales at the moment, particularly in our A&E departments?

[11] **Dr Jones:** First, we have to realise that unscheduled care is wider than just general practice, as outlined in the report. Obviously, you want to focus on access, frequent flyers and the pressures on A&E. I completely accept that, and we welcome the opportunity to come to speak to you today about that.

[12] General practice is seeing well over 6 million to 7 million consultations per year, which is actually over 90% of the activity of NHS Wales. We do not think that that has been

captured in the Wales Audit Office report. General practice surgeries are open between 8 a.m. and 6.30 p.m, and within that time we have to balance the needs of those who have acute new problems that need to be dealt with quite quickly—essentially, on the day, or very shortly afterwards—versus those who need continuity of care, and the whole plethora of everything else that comes into general practice. We must not forget that an enormous amount of work goes on within general practice that is probably not needed. If we could look at that we could free-up more access and capacity within general practice. However, the needs of the patients of a general practice population are met because, simply, we finish the work of the day.

[13] On A&E attendance, having been a GP manager of an out-of-hours service—and I still work regularly out of hours—and worked within the Welsh ambulance service team on its control desks and also within emergency departments, I think that I am fairly credible in speaking about how we can look at the whole system. We need to think about the whole-system approach, and not just focus on one aspect of the system. Given that I have worked out of hours, I think that we have to have some very real, honest conversations about what is achievable. Do we really think that it should be about what is convenient for patients and what it is that they want, or should it be about what they need? There is a lot more that we need to do around self-care, and educating the public about the services that are available out there. I do not think that we use our other colleagues, such as optometrists, as much as we can do, and I do not think that patients particularly use NHS Direct Wales as much as they could, or pharmacists. We have to accept that some patients will always choose to turn up at the casualty department. When someone contacts me in an out-of-hours centre, whether I am based in the casualty department or in the GP centre, I always ask what prompted them to ring me rather than to see their own GP. Sometimes, it is down to convenience and sometimes it is simply because they are closer to casualty, or the fact that they feel that they get a more specialist opinion. So, I think that we need to do a lot of public education as to what is available out there and what is appropriate. We need to look particularly at self-care, and then, of course, within general practice, at freeing-up the time that we use to do unnecessary work to enable us to meet more of the needs of those who require GP services, whether it is for acute problems or for ongoing chronic illnesses.

[14] **Darren Millar:** Okay. So, to get this right, the WAO report is telling us that demographics and the ageing population having more chronic conditions are some of the factors that have led to an increase at the hospital front door, if you like. It also points to some people suggesting that difficulty in accessing GP primary care appointments is making them turn up at the hospital front door, but you are saying that that is not necessarily the problem here. You have even suggested that GPs are able to be accessed between 8 a.m. and 6.30 p.m. I know that I cannot get into my GPs surgery at 8 a.m. ever, or indeed beyond 5 p.m. in the evening. Why is your perception so markedly different to that of mine, my constituents and the Wales Audit Office?

[15] **Dr Jones:** Your surgery should always have somebody available to meet your need between 8 a.m. and 6.30 p.m. Whether you are physically able to have an appointment between 8 a.m. and 6.30 p.m. is a different story, but there should be somebody available to speak to and sort your problem out. A lot of people can have telephone consultations; certainly within my own practice, we have seen a 40% to 50% increase in telephone consultations. Within the practice, we still offer on-the-day bookable appointments, we offer follow-up appointments, and we do home visits. All of that has to be fitted into the working day, but there is always somebody available in the practice to take the call and to then direct it to the appropriate person.

[16] One thing I would like to bring up as well, while we are on the subject of general practice, is that general practice is about our capacity within the working day. A lot of people think that it is just about seeing patients; an awful lot of work goes on around that as well, and we must not forget that there is a very real workforce crisis. I know that you, up in north

Wales, will be only too aware of the difficulties of recruiting GPs into general practices, and that will invariably affect access, I am afraid. The GPs left behind are trying to do all the work while trying to find more GPs to come to help.

[17] **Darren Millar:** Okay. There are a number of Members who want to come in, but I will give you an opportunity to respond first, if you want, Dr Bailey.

[18] **Dr Bailey:** It is worth just looking at the numbers a little bit, which, interestingly, appeared at the very end of appendix 2, on page 87, I think, of the Wales Audit Office report. What those numbers showed—and we would probably challenge the actual quantum slightly—was that of the 8 million unscheduled appointments, nearly 5.5 million took place in primary care, and another 1 million of those were counted as phone contacts to NHS Direct, which, as you know, has a completion rate of about 25%. We would probably say that that 5.5 million was probably nearer 6.5 million out of the 19 million consultations that take place in general practice every year. It represents the lion's share, basically. Most people who look at casualty attendance will tell you that maybe as much as 20% of the consultations are inappropriate or could be better dealt with elsewhere. I would not necessarily challenge that figure particularly, but if you just look at the sums, you will see that it is suggested that maybe 200,000, at the most, consultations in casualty across Wales every year are taking place that might be better dealt with elsewhere, which is about one-thirtieth of the number of unscheduled appointments that take place every year in Wales in in-hours general practice, and which is slightly less than the unscheduled appointments that take place out of hours.

[19] The out-of-hours issue is a big issue for you at the moment. The amount of money that has been put in to out-of-hours services, which, let us not forget, are delivered or led by GPs right the way across Wales, has not moved since 2004. It is about £30 million, which I think is less than was paid recently for a catch-up programme for orthopaedic waiting lists. So, the whole of out-of-hours unscheduled care in Wales is valued at significantly less than an orthopaedic waiting list programme. So, I think that that is the issue that perhaps needs to be addressed.

[20] **Darren Millar:** Okay. We will touch on some on these issues in a bit more detail. Some Members want to come in here. Aled, then Jenny, then Oscar.

[21] **Aled Roberts:** Hoffwn godi dau bwynt. Mae paragraff 3.12 yn yr adroddiad yn dweud mai ond 35% o bractisau doctoriaid oedd ar agor am yr oriau craidd yn 2012. Mae hynny i fyny dipyn ar y flwyddyn gynt. Fodd bynnag, nid wyf yn gweld sut mae hynny yn cyd-fynd â'r hyn ddywedoch chi, sef bod pob meddyg teulu ar gael, neu bod y feddygfa ar agor, rhwng 8 a.m. a 5.30 p.m.; mae'r ffigurau hyn yn nodi mai dim ond 35% ydyw.

Aled Roberts: I want to raise two points. Paragraph 3.12 in the report states that only 35% of GP practices were open for the core hours in 2012. That is up quite a lot on the previous year. However, I do not see how that correlates to what you said, namely that every GP is available, or that the practice is open, between 8 a.m. and 5.30 p.m.; these figures note that it is only 35%.

[22] A oes gennych unrhyw sylw i'w wneud ar y ffaith bod y ffigurau yn eithaf cyson o ran ymweliadau i adrannau damweiniau rhwng 1987 a 2004, ar lefel Brydeinig—rhyw 14 miliwn i 15 miliwn o ymweliadau—a bod y ffigur ond wedi cynyddu, i ryw 50%, ar ôl i'r cytundeb newydd ar gyfer doctoriaid teulu gael ei gyflwyno yn 2004? Ffigurau yr Adran Iechyd

Do you have any comments to make about the fact that the figures are quite consistent in terms of visits to A&E departments between 1987 and 2004, on a British level—some 14 million to 15 million visits—and that the figure has only increased, to about 50%, after the new contract for GPs was introduced in 2004? These are figures from the Department of Health in England, but the figures that I

yn Lloegr yw'r rhain, ond mae'r ffigurau yr wyf wedi eu gweld o ran Cymru yr un peth, bron.

have seen for Wales are pretty much the same.

[23] **Dr Bailey:** Could I perhaps come back to that? Very recently, when we were talking about casualty figures and the new contract, Jeremy Hunt was quoted as saying that the figures had gone up from 18 million to 21 million in the UK from 2004 onwards. However, the first thing to say is that the new contract, in terms of out of hours, did not really take place until about 2005; that figure actually came about a year earlier. It was found that that the figure of 18 million major consultations in the major units and the 3 million minor consultations in the minor units had been added together. In fact, the number of increased consultations in 2004 was very small—less than 5%. The movement from GP co-ops and 24-hour responsibility did not actually take place until about September 2005, because, although it was agreed in 2004, there was obviously a lot of organisation involved in doing that. Since that time, the investment from the Welsh Government—and, indeed, from the Governments across the UK—has been absolutely flat in those services, while consultation rates are going up. The UK Government's workload survey from 1997, compared with the one in 2008, showed 50% more consultations in primary care in-hours, and I think that that has probably been mirrored quite closely out of hours.

[24] Therefore, some of those figures are being misused, certainly by the Secretary of State in England, and it was demonstrated quite clearly in the press shortly afterwards that, actually, he had misquoted those figures. I think that the increase year-on-year has been slightly smaller in accident and emergency units than it has in primary care, where it has been about 4%. However, inevitably, across the whole of the UK, there will be increases, because patients are getting older—and older patients are sicker—the population is growing, although slightly less in Wales, but it is still growing, and because demand is getting higher. Given that we can do more, and because there are more things available, you can offer patients more services, and, if you can offer patients more services, clearly they will attend for them.

[25] **Aled Roberts:** You mentioned spend on out-of-hours contracts several times. What is the difference in terms of actual spend on GP contracts between 2004 and now?

[26] **Dr Bailey:** It has gone up by less than 1% a year. The national health service figures for GP incomes show that, over five of the last six years, they have actually gone down, and the general medical services total spend across the UK has gone up by less than 1% a year, for several years. That is far behind the total spend in the NHS overall.

[27] **Dr Jones:** Regarding the GMS moneys—the contract—Welsh Government figures will show a slight increase of around 1.2%. However, that is accounted for by the increase in the population—the increase in the amount of a quality and outcomes framework point is not actually due to any new investment.

[28] I would like to come back to the casualty figures, if I may. The casualty figures do not count like for like, because it depends on the unit. My own unit, for example, will count anyone being admitted by me, who will go through the casualty unit, and is admitted into a hospital bed. So, that is counted. When I work out of hours, I am actually co-located next to Morriston Hospital, so if a patient presents to casualty, and they get referred on to me, because they have inappropriately gone to casualty, then that is still counted as a casualty attendance. Therefore, we have to have a little bit of wariness about those figures. That is not to say that the casualties are not working hard, but we cannot be sure that we are counting like for like, whereas, when they contact the out-of-hours service, it is an actual face-to-face consultation, or a telephone consultation and so on.

[29] With respect to the contract opening, practices have to be available between 8 a.m. to

6.30 p.m. We are not here to defend those practices that are not offering adequate access to patients. In fact, Dr Bailey and I took quite a significant amount of criticism some 18 months ago when we implemented a policy called 'sort it in one call'.

09:15

[30] We understood the frustrations of patients who phoned on a day and there was no appointment available and were told to ring back the following day; we appreciated that. We said to practices, 'You cannot carry on providing services in this way. You have to look at what is reasonable for your patients' needs'. It will be different in my practice and it will be different in Dr Bailey's practice, because we all have very different populations. We have taken an enormous amount of criticism. We will continue to work with practices and say, 'You need to have reasonable access for patients'. However, to criticise the access, I think, is wrong. You do not need a GP to see you from 8 a.m. to 6.30 p.m.; you need somebody available to manage your problem. That can be managed in a variety of ways.

[31] **Aled Roberts:** A ydych chi'n derbyn bod y ffigur o 35% yn gywir?

Aled Roberts: Do you accept that the figure of 35% is correct?

[32] **Dr Jones:** We would argue that it is not, because they have only been capturing this data for the last year through the annual operating framework. We believe that, because there have been differences in how practices have understood the information being requested and differences in how health boards have been asking for that information, it is not accurate. I think that you will find that it is now on the tier 1 level reporting of health boards, within their annual operating frameworks, on those practices that offer appointments at the tail end of the day. I believe that the figure is actually lower in some health boards, but it is, I think, around 82% in ABMU health board. I cannot remember the figures off the top of my head, but there is a significant improvement. I think that practices are aware that they need to provide good access for patients, but we need to be sure that we are capturing all means of access during that time, so it is not just, 'Are your doors open?'; it is, 'What do you offer patients and what services are there for your patients?'.

[33] **Darren Millar:** Okay. We will look at lots of these issues in more detail during the course of our questions, but a number of Members want to come in here and I want to bring them in, so that we can move the conversation on. Jenny Rathbone is next.

[34] **Jenny Rathbone:** On the numbers, are you able to tell us how many full-time equivalent GPs there are in Wales? You have told us that you have 7,000 members, but that is across all specialties. Do you have that information?

[35] **Dr Jones:** Yes, we do.

[36] **Dr Bailey:** There are about 3,000 GPs, of whom, probably 800 are non-principals in Wales.

[37] **Jenny Rathbone:** Some of them will choose to not work full time. I am aware of that.

[38] **Dr Bailey:** Yes, the non-principals will not necessarily work full time. We do not have figures on full-time equivalents. The average GP on the workload survey works a working week of nearly 46 hours, therefore, comparing full-time equivalents, which, in the NHS salaried sector is 37.5 hours, is slightly difficult.

[39] The number of hours worked by full-time GPs has gradually crept up between workload surveys—there are three over about two decades—and certainly, the most recent

figure is close to 47 hours. That is despite the fact that GPs no longer have responsibility for out-of-hours services, whereas the first survey will have taken account of the out-of-hours time that they worked. That reflects the fact that, in-hours, it is far more intense and that people are staying far longer. When I first came into practice 28 years ago, I could quite easily wander off into town for three hours in the middle of the day. I am lucky if I can get half an hour for lunch now.

[40] **Dr Jones:** I would like to add to that that we are aware that, in the last year or two, GPs are having to cut back on some of the sessions that they do because of the intensity and the stress of the job. We are very anxious about that. We are noticing that fewer GPs want to work out of hours, or can take on other roles to develop patient services, because the intensity of the workload in the working day is so high. We also have a number of GPs who are rapidly approaching retirement. We have a workforce crisis, which, as we have been pointing out to Welsh Government, is coming—it is looming—quite quickly. We have to remember that what we currently have is a finite pot of GPs out there. General practitioners have an enormous amount of skill and can deliver a range of services within the primary and secondary care settings and beyond, but we have a finite source. So, anything that we do over and above delivering services to patients dilutes the work that we can do on anything else. We need to urgently address that.

[41] **Jenny Rathbone:** You have 3,000 GPs and some of them are not principals, but they are still doing the job of a GP as far as the patients are concerned.

[42] **Dr Jones:** They tend to work in a portfolio of careers, and a lot of sessional GPs choose to vary their workloads according to other interests, caring roles, or childcare, et cetera.

[43] **Jenny Rathbone:** So, although we have 3,000 GPs, we do not actually know how many are full-time equivalents.

[44] **Dr Jones:** No and that is a criticism that we have always had. You can look at the consultant workload expansion, which has been over 30% in the last few years and you can see that going up naturally, because it is quite easy to get figures on the numbers within the workplace and what they are working. We have encouraged health boards all the way along to look at the GP population that they have and try to start capturing how many sessions they are doing and how that equates, because we actually need to know what we have and what we need going forward.

[45] **Jenny Rathbone:** However, this is something that the Welsh Government should have, because it is paying for the sessions that people are doing.

[46] **Dr Jones:** It depends if they are capturing that through their health boards. It is certainly work that we keep trying to do, and it is very difficult.

[47] **Darren Millar:** I suppose that the question, Dr Jones, is how many more GPs we need in the future. You said that there is a crisis; if there is a crisis, how many are we short?

[48] **Dr Jones:** If you look at England, where they have identified that they need to increase the number of GPs by 20%, you will see that they are going to increase it by 10% as a starter. If you look at the number of GPs in training that we have, which is around 134, you will see that that has been static for many years, and that is currently only enough to stand still. If we were to follow England's lead we would need to be training nearer 200. We should also remember that, in England, they are trying to get 50% of all doctors in training to be GP trainees. If we were to do that in Wales, we would be looking at significantly more numbers of GP trainees. So, we would need 200 to model England purely on general practice, and if

you want to go to foundation training, it would be hundreds more, but where are we going to find them? That is another issue.

[49] **Darren Millar:** So, that is 200 new GPs per what?

[50] **Dr Jones:** Yes, 200.

[51] **Darren Millar:** Is that per annum?

[52] **Dr Jones:** Yes, per year. We have to remember that, of the 134 that we currently have, there are around 20 to 30 who are currently what we call 'out of programme'—having a break, typically for maternity reasons, or if they have had extensions of training. Also, if we bring in the four-year extended GP training, that will mean that there will be a little reduction in the numbers of GPs coming out of the end of training. However, that is certainly something that we think should be invested in for the future.

[53] **Darren Millar:** Okay. A few more Members still want to come in. I will call on Jocelyn and then Julie.

[54] **Jocelyn Davies:** I was just wondering why you thought that patients would sit for hours in an accident and emergency department, which is a very unpleasant experience, if there were services readily available from their own GP. Why would anyone do that?

[55] **Dr Jones:** Do you know, I have that conversation all of the time. When patients ring up in the morning and I say, 'We can see you at 10.50 a.m.', they will say, 'I will go to casualty, then', and I will ask why. If someone rings for a home visit, I always ring them back to assess how urgent it is and whether I need to leave a surgery waiting room full of patients or whether it could be done in between surgeries. Sometimes, patients just will not wait. They will say, 'I will call an ambulance and go to casualty'. I will say, 'You are going to be waiting for eight hours. If I come and you need to go into hospital, I can organise for you to be admitted to the assessment unit. If you choose to go by ambulance and go to a casualty waiting room, who knows how long you will be there?' As you say, it is uncomfortable and cold; it is not the most pleasant environment when you are feeling sick, unwell or worried. I think that we need to get a public education message out there about the fact that it is not all about convenience. If you need an appointment and you need to be seen, or you need to speak to a doctor, they will do that for you, but do not necessarily go to A&E; it is not the right place for you. We need to think wider than just the GP services. We need to advise people as to what is available and what is appropriate.

[56] **Jocelyn Davies:** So, in your experience, a patient that was offered an appointment later that morning would go to A&E rather than wait until later that morning.

[57] **Dr Jones:** I am afraid that some individual patients will do so. Some patients who live nearer casualty will, again, choose to go to casualty. I spent a week in a casualty reception on two occasions, as a manager of an out-of-hours service, looking at the reasons why patients attended. We asked them why they had chosen to attend there. We covered 999 cases and everyone who walked through the door. A significant number said that it was because they wanted to and that it was more convenient to just turn up at casualty. When we asked, 'What about waiting and speaking to your GP?', they would say, 'Well, I don't know whether there will be a convenient appointment'. So, we would say, 'You are going to be waiting here for hours on end', to which they would say, 'Oh well, it is okay; it is a hospital'. Some people think that they get a more specialist opinion in a hospital. Again, we have to educate people about that because, actually, A&E departments are very good. They do a lot of very good work, but they are not good in the conditions that we manage in general practice, and even A&E consultants will confirm that.

[58] **Darren Millar:** You mentioned this local work that you did. Were they out-of-hours sessions?

[59] **Dr Jones:** No, they were 24/7. A group of the monitors of the out-of-hours service went into casualty because there were a lot of claims about the sheer volume of apparently primary care patients turning up at A&E. Our modelling on two separate occasions showed that it was less than 10%.

[60] **Darren Millar:** Do you have copies of the data?

[61] **Dr Jones:** They would be available from Abertawe Bro Morgannwg University Local Health Board. ABMU health board has that, as does the ABMU out-of-hours service.

[62] **Darren Millar:** We will try to sort that.

[63] **Julie Morgan:** I must say that I am astounded that patients who are offered an appointment at 11 a.m. choose to go to A&E instead of that. Do you have evidence of that and actual numbers that you could give us? I am amazed at that.

[64] **Dr Jones:** No, we do not. It is only through speaking to patients and, actually, what we have been trying, for some years in the out-of-hours setting, to ask is, 'Did you contact your GP or did you think about contacting your GP during the week?' At the moment, our IT system allows us to capture it only in free text form, so that is of no value; you cannot extract those data. I do believe that some patients are using out-of-hours services as a convenience, and I think that we need to look at the IT system to be able to capture that because, again, all that I can bring you is anecdotal information.

[65] **Julie Morgan:** So, it is anecdotal information that people refuse 11 a.m. appointments, and will go—

[66] **Dr Jones:** It comes from having sat in a casualty setting for two weeks 24/7, asking people why they had chosen to come to casualty rather than go anywhere else, and it is also from working in an out-of-hours setting, where you are speaking to patients in the evenings and at the weekends, asking them whether they contacted their GP and, invariably, the answer is, 'no'. However, we need to start capturing that more formally.

[67] **Julie Morgan:** I suppose that I was just a bit concerned about that particular example that you gave—you were saying that they had not contacted their GP—where you said that they had contacted the GP and they had been offered an appointment. That information was given to you as well.

[68] **Dr Jones:** It does not make much sense to us, either, but I am afraid that that is the reality of the situation. Casualty departments need to start capturing this information as well. Were they offered an appointment—yes or no? If 'yes,' why did they not want that appointment? What was wrong with that appointment?

[69] **Dr Bailey:** May I also make a couple of points? The first is that some work was done by the Welsh Assembly Government in 2007 that demonstrated that the demographics of the people who attended casualty, particularly in-hours, was quite different. As you would expect, there was a huge skew for closeness to the casualty department, and practices that were very near to the casualty department had a much higher attendance. However, the second is about the demographics of the patients who attended: it was far more likely to be younger men who attended casualty compared with the average attendance in general practice. I think that the other thing to look at is the actual figures. Over 19 million consultations take place every year

in general practice, and the most generous assessment of the inappropriate attendances at casualty in the whole of Wales suggests that it is 200,000. That is less than a hundredth—it is less than 1%—of the total number of people who attend general practice. It is difficult to believe, therefore, that some change in the way that appointments are offered would suddenly persuade those 200,000 people to do something different.

[70] What we do know is that when GPs are at the front of house, before they go any further, they can cut down the number of people who need to go through to the casualty unit by an enormous number, because GPs are risk managers, whereas the people who see patients at the front end of casualty, by and large, tend to be first or second-year qualified doctors and are less likely to manage the risk, because they do not have sufficient skills to do so. I fully remember being a casualty officer over 30 years ago and admitting or getting second opinions for patients with relatively minor conditions, because I did not have the confidence to say, 'You should just go home'. However, GPs can do that and the evidence, certainly in Swansea, where it has been done, shows that that would dramatically reduce the number of inappropriate attendances.

[71] **Dr Jones:** The other thing that we would like to say—

[72] **Darren Millar:** Be brief and then we will move on.

[73] **Dr Jones:** There are schemes in place in Carmarthen and also Aneurin Bevan LHB area, where, if somebody turns up to casualty and it is felt that they should be seen in general practice, the casualty department is enabled to tell them that and to signpost them back to the practice, but these are rarely used. Certainly, within the out-of-hours setting, when we first started at Morriston, it did not refer many to us, but as soon as it realised that we were seeing them quickly, we were deluged with them. So, it is interesting if you look at the figures where you have co-located out-of-hours services, but, in-hours, where there are schemes in place where you can refer patients back to the practice, they are not being used very well and we need to look at the reasons why. We think that it is because either the individual seeing them in the casualty unit does not feel confident enough to turn them back to their own surgery, or, sometimes, there is a perverse incentive to keep your numbers up, and I certainly know that that would be true of one or two units that I have heard about. So, I think that there is more work to be done. We do not have enough GPs to put in every casualty, on every front line or in every ambulance control centre. That would be ideal, but we do not have enough GPs for that.

[74] **Jocelyn Davies:** May I just ask which ones—[*Inaudible.*]

[75] **Darren Millar:** This is the perverse incentive.

[76] **Jocelyn Davies:** —in a way that would just keep the numbers up?

[77] **Dr Jones:** Some of the nurse-run minor injury units would count the patient as attending, even if they then divert them back to the GP in-hours or out-of-hours and so, to me, a lot of their funding depends on the numbers attending their unit, so there is a pressure there to keep their numbers up.

09:30

[78] **Darren Millar:** You must be aware of specific examples of this, so which particular minor injuries units would you—

[79] **Dr Jones:** Certainly, if somebody turned up to a nurse-led minor injuries unit that cannot deal with the presenting problem, they should not count that patient as having been

seen and managed by them. So, I would suggest that you may want to take a closer look at some of those units, which are scattered across Wales. If somebody comes in with, say, a sore throat, or a skin infection, they are counted—they have arrived in the unit, so they are counted. They are often given a number for the GP out-of-hours service and told to ring from outside the unit, yet they are counted in the figures.

[80] **Darren Millar:** Tell me, if people turn up at your GP surgery but what they need is an immediate emergency intervention, do you count those as people who have turned up at your surgery?

[81] **Dr Jones:** If I have managed the intervention, absolutely, yes.

[82] **Darren Millar:** In the same way, would that not be appropriate if a patient has turned up at a minor injuries unit and they have had to manage, or signpost, that patient? There is an intervention that they are making, is there not, in somebody's care?

[83] **Dr Jones:** I do not think that they are making an intervention; they are just giving them a telephone number. I do not just do that—I see the patient, assess them, examine them, take a history and manage them appropriately. I do not just say, 'Oh, you have to go straight to casualty; that looks broken'. They just take the demographics and say, 'We cannot do this in this unit—you need to ring the GP out of hours'. If they handed that patient over to the service and did a professional-to-professional talk, then absolutely; but when they just hand over a telephone number and tell the patient that they are in the wrong place, no. I do not think that they should be counting that. If you are looking at the activity of a unit, it is different to the effectiveness of a unit.

[84] **Darren Millar:** Okay; I understand that.

[85] **Sandy Mewies:** I have listened very carefully. You have made a number of points—actually, an awful lot of points; some of them, you will not be surprised to hear, have already been made to us—about how things can be improved by co-location and ensuring that frail and elderly patients, even though they may pass though A&E, take a different route to different services. You mentioned direct referral by an optometrist, for example—I hear from work that I have done that some GPs are not terribly happy about that happening. It is a big Wales, sometimes, is it not? The things that you have suggested, we have heard about. We have heard from David Sissling that there is good practice going on, and we have asked for examples of that.

[86] I would like to get back to this point about people ringing up the doctor and saying, 'I want an appointment now', and being told, 'No, you cannot have one', and then going elsewhere. I think that there could probably be lots of reasons for that, but you see, in north Wales, I really do not see, if you live 40 miles from your nearest A&E unit, that you are going to do that; a lot of people do live 40 miles or more from their nearest A&E unit. It would be a heck of a thing to say, 'There is my doctor's surgery, about 2 miles away, and I am going off to A&E'. So, I would like to ask you about the consistency. You told us that, when you worked for a fortnight 24/7, you heard people telling you that, and I wonder if you could say, for example out of 100 people, what was the percentage? I know that it is not going to be terribly accurate, but it is an idea, is it not? Was it 50%, 2%, was it a lot, was it a few? I think that we have all been quite surprised at what you are saying there.

[87] You were also saying—we recognise that the numbers may not be the same for everyone—that we need more GPs. We find it very hard to attract GPs, and particularly—as I am sure some of the north Wales Members, and the rural Members, will know—we have rural surgeries closing, and it is not through a lack of trying to recruit. There is a problem of recruitment. It is easy to say that we need 200; what are your ideas for getting them here? My

last point is that lots of general practices that I know are very helpful to people who work—I might be fortunate where I live; I do not know. I think that we have to accept that not all general practices are the same. Have you got any suggestions in how we can improve that accessibility? I am thinking about things like missed appointments. We have all seen the list: 'this many appointments missed this month'. What do you do about it? I think that it is serious when people do not turn up for an appointment. You have identified the problems, but you are working on the front line, both of you, so how do we solve it?

[88] **Dr Jones:** First of all, with regard to the numbers, I think that we have to accept that where I am in Swansea, the population is a very different one to that in the rural parts of Wales. It is very easy to get to a number of the units where I live; it is not difficult. They are on bus routes as well, which also makes it easy. So, I think that we have to accept that it is very different across Wales.

[89] With regard to attracting GPs to Wales, this is something that we have been saying for a long time. We have developed a paper for Welsh Government, which it has, about solutions for the imminent crisis. The reason for that imminent crisis is that, very often, workforce planning for general practice is very difficult. We have heard from Ms Rathbone here about how to identify how many whole-time equivalents we have. It is a bit like the chicken and the egg or a needle in a haystack—we want to reconfigure services; what does that mean for our workforce? It is just going round and round in a circle that never changes.

[90] **Sandy Mewies:** The chicken and the egg is something that I have thought about a lot of times while you have been here.

[91] **Dr Jones:** It is very difficult, and I cannot begin to say that they have the answers for that, but what we know is that there is a very real crisis now. So, we have drawn up some solutions for Welsh Government to look at. Some will be for individual practices, while some will be for health boards to look at, and some will be for Welsh Government itself, such as rural scholarships. We know that if you have people living in an area for a few years, they tend to stay in that area. We need to make sure that, if they need childcare, there is easy access to it. For the spouses, we need to make sure that there are employment opportunities. It is all those sorts of things. That has all been wrapped up in a number of solutions that we have suggested to Welsh Government.

[92] With regard to getting enough GP trainees, I completely agree; what we do not want is just to train up a whole load of GPs for them to go, or to have anybody who thinks they might want to be a GP who is not of the right quality and calibre to be one. It is a fine balance there, and we are working through that. However, as I said, there are solutions out there, and there are suggestions that we have made to be helpful and proactive in this, to try to direct some momentum and movement behind this.

[93] With regard to accessibility in general practice, it is as I said before; we are not here to defend the indefensible. We think that general practice is on its knees—well, we know it is. Workload capacity is stretched; it is absolutely stretched. So, there are times when patients are going to ring up and they are not going to get an appointment, or they are going to be told to ring back the next day. I have outlined to you how ours are sorted in one call, and we are continually working to advise practices that they really need to be taking a step back from the stress and strain of every day to think about how they are delivering services to practice. It is very difficult when you are deluged with 40, 50, or 60 calls a day and patients and home visits. It is difficult to stop to ask how you could improve the services for your patients. Or is it just that that demand is there and it has to be met? It is very difficult to balance the two.

[94] With regard to learning for practices, it is sometimes not helpful when practices have somebody come along and say, 'You're not doing your job very well; patients cannot get

appointments'. That can be really hard to hear when you are working flat out. So, what we have suggested as part of the negotiations for this year is that networks work together and look at how they provide access to patients and a whole provision of services, and they talk to each other to share good practice. Sharing good ideas might make you think, 'Oh, that might work in my practice; let's have a think about that'. So, it is going to have to be, I believe, driven by the profession and discussions as to what we can do, but we have to accept that practices are, I am afraid, on their knees at the moment.

[95] **Dr Bailey:** I would just add a couple of extra things to that. In making sure that we make best use of the resource that we already have, we have to address the issue that some practices are still using the largely discredited English invention of advanced access, which basically means that everybody has to scrum along at 8 a.m. to try to get an on-the-day appointment. We conducted a campaign two or three years ago from GPC to suggest that, actually, that is no longer acceptable, and that, if a patient rings, when they get off the phone, whether or not the appointment is on the day, they should know when they are going to be seen or have a consultation, whether it is by telephone, with a nurse, or whatever. We think that that is a minimum standard that we all ought to be trying for.

[96] In terms of 'did not attends', it is as much as 10% in some cases, and that has a huge impact. We would not suggest going along the payment route, although it is interesting to note that southern Ireland has a consultation rate in general practice of two and a half, whereas Northern Ireland has a consultation rate of six, the only difference being that one pays and one does not. The difference in outcomes is very small. So, there is an issue around that.

[97] One of the things that we are doing in our practice is texting—you can now get text bundles remarkably cheaply—to remind patients on the day. We have had a campaign over the last two or three years to try to get mobile numbers from as many of our patients as we can. That has certainly cut down DNAs significantly, although not completely. It is astonishing to me that people can make an emergency appointment at 11 a.m. and forget to turn up at 4 p.m., but that happens, and it happens every day. So, there are issues in terms of patient use as well as doctor use. However, it is absolutely right that a doctor cannot start saying 'We are providing a good service' if, three times in a row, a patient phones up at 8 a.m. and is told 'Phone back tomorrow'. That is not acceptable. We have said quite clearly from GPC that that is not acceptable, although, as Charlotte said earlier, we took a certain amount of flak at the time for doing so.

[98] **Sandy Mewies:** Welcome to our world. [*Laughter.*]

[99] **Dr Bailey:** The other issue to remember is that the total investment in general practice is reducing. As a total proportion of NHS spend, it has gone from 10% in 2004 to less than 8% now. At the same time that public policy is suggesting that more should be done in primary care, less is being invested in it. That is an issue for the Government that you do have to think about addressing.

[100] **Sandy Mewies:** I would like to raise a few points on that. I asked whether you had a ballpark figure about the people you have talked to in order to reach the percentage figure. The other thing, in relation to missed appointments, is to ask how tough GPs and those in A&E departments should be in saying—as you said—'You shouldn't be here'. It is quite difficult at 2 a.m. on a Saturday or Sunday morning to say 'You shouldn't be here'. How tough would you expect people to be on missed appointments? It is disgraceful that people do not just miss one, but miss other appointments. If you handle that and if you can get rid of that percentage, which is quite high in lots of practices, it might free up some time to see people who genuinely do need to see a GP. It is subjective, is it not? You do get a lot of flak. Whenever politicians suggest things that are unpopular, we can get a lot of flak, but

sometimes you just have to go ahead and do it.

[101] **Dr Jones:** I am sorry, I missed the casualty figures, and I apologise for that. Was it a rough percentage of the patients turning up inappropriately, or the number who did not contact their GP? I am sorry, I was not quite clear.

[102] **Sandy Mewies:** I was interested in the ones who you said had been offered an appointment at their GP practice but had chosen instead to go to A&E.

[103] **Dr Jones:** I do not recall the figures for that, but they were very low. I recall a figure of around 7% to 10% who should have been seen in general practice. So, it would have been a proportion of those.

[104] The other thing that I would like to say is that we have taken the bull by the horns a little bit in that GPC Wales will be launching a consultation strategy before the new year is out. One of the areas in that will be access. It will go to patients and politicians, but it will also go to the profession. The aim is to start challenging some of the practices and saying that we need to be more of a patient-focused service provider, rather than thinking about the business and the running of the practice. It needs to be more about the patient.

[105] **Sandy Mewies:** Could we see your solutions paper?

[106] **Dr Jones:** Yes, we will send that through to you. You are very welcome to it and any movement you could make on it would be very helpful; thank you.

[107] **Darren Millar:** On this issue of do not attends, you mentioned the situation in the Republic of Ireland where, of course, they charge for appointments, but what about charging for non-attendees? If somebody does not turn up without a reasonable excuse, do you think that it is reasonable then to say, 'You ought to be—

[108] **Dr Jones:** The question is how you police that, though, is it not? It would be messy.

[109] **Dr Bailey:** That would be difficult. Dentists do that, and that is probably quite reasonable in dentistry, frankly. With GPs, unfortunately, it is the case that the percentage of people who do not attend is higher among our most deprived and our most chaotic patients. While, in an intellectual sense, you think that that might persuade people, I do not think that it would be terribly helpful in terms of providing an equitable service for the patients who need it most.

[110] **Darren Millar:** Why is that okay for dentists, then?

09:45

[111] **Dr Bailey:** It is partly because they are dealing with slightly less life-threatening conditions and because, to some extent, most of their patients are contributing towards the payment anyway and are much less likely to do it. If they do fail to turn up, it is quite clear that they would expect to pay. I do not think that I can say to my drug-addict patients who forget the appointment that they have that afternoon, 'I'm sorry, you've got to pay now before you can come and see me again'. I look back to my 18-year-old self who would have been appalled to hear me say this now, but 30 or 40 years of working in general practice makes you realise that there are an awful lot of shades of grey and very little black and white. I do not think that that is a viable position. If I could select the patients who I thought were taking the mickey—patients who are perfectly capable of remembering to keep an appointment and did not because something better came up—then fine, but, actually, you cannot do that; it would be discriminatory and impossible to police anyway. Like Charlotte and most other GPs, I

have a significant number of patients for whom, frankly, that would be detrimental to their health, and, to some extent, you just have to suck it up.

[112] **Dr Jones:** It is obviously potentially detrimental to the doctor-patient relationship, and, as David said, sometimes the patients have life-threatening conditions, and the continuity of care in that relationship is very difficult. There has been—

[113] **Darren Millar:** The other side of the coin, though, is that it is detrimental to the doctor-patient relationship when a patient cannot get an appointment. So, what about penalties against GPs who fail to deliver on accessibility between 8 a.m. and 6.30 p.m.?

[114] **Dr Jones:** I certainly think that GPs—

[115] **Darren Millar:** Should there be a financial penalty if they do not deliver their part of the bargain, as it were?

[116] **Dr Jones:** Well, already, if practices are not delivering on their part of the bargain, the health board has the ability to go in and manage that. So, if that is happening, then I would be saying to the health board, 'Go in and sort that out'. They can already do that—it is a breach of contract.

[117] **Dr Bailey:** In my practice, certainly, the number of people who want an appointment on Monday morning might be anything from 45 to 125, and we can demonstrate those figures, but my practice is big enough to manage that risk. If you are an individual doctor, and one day 150 of your 2,000 patients all want to be seen on the same day—it happens very rarely, fortunately, otherwise we could not manage the system, but sometimes that sort of thing can happen. The flu pandemic in 2010 increased our phone consultation rate by about 700% over about a fortnight. Those sorts of things can happen, so it is very difficult to manage GP access on a day-to-day basis, although I might be more amenable to looking at, over a much longer period of time, whether you are providing adequate services, because, actually, the contract says that you should provide adequate numbers of consultations for your patients' needs, and LHBs have a responsibility to police that. If they are doing that on an annualised basis, I think that is a reasonable thing to do; I do not think that you can do it on a day-to-day basis.

[118] **Dr Jones:** Where they identify that there is a problem, I do think they should go in and talk to that practice, because there may be problems within that practice and it may need some support and help.

[119] **Darren Millar:** Okay. I am going to bring Mike in, and then we will have to move on.

[120] **Mike Hedges:** There are huge variations between GP practices. I have one in Brynhyfryd, which I am quite happy to speak about. I ring them up at 9 a.m., they say 'Turn up at 11.30 a.m. and the doctor will see you', and the longest that I have ever waited is 40 minutes—the normal length of wait is quarter of an hour. I also know of practices near where I live in Morriston, where you ring up at 8 a.m. and by the time that you get through at 8.10 a.m. there is nothing available. The only person that you can ever get to speak to is the receptionist, who tells you, 'You'll have to ring again tomorrow'. People ring the second day, they have a sick child, and are still being told, 'You'll have to ring again tomorrow', so they drive up to A&E. There is a huge variation. If everybody worked like the best—what you talked about, Dr Jones, is very similar to what happens at the practice that I go to—

[121] **Dr Jones:** Because it is very similar in its working ways and patterns.

[122] **Mike Hedges:** Yes. However, there are others—. Take home visits; you talked about

home visits. My GP does home visits, and also does not kick people out of the practice if they happen to move further away, which is also something that GPs do: if you move more than two miles away from the practice, you are told, 'Sorry, you'll have to find another GP now'. I speak very highly of my GP practice in Brynhyfryd, which I think is superb, but, from talking to my constituents, I know that very few of them get that level of service.

[123] **Dr Jones:** It is difficult, because no one solution fits all practices. Every population is very different. Where I am in Swansea, the practice down the road and the practice up the road have very different solutions to meet the needs of their patients. I do not think that we get it right in our practice all the time. I have been horrified sometimes when I hear the receptionist saying, 'There's no appointment available' or, 'You want to see Dr X, you'll have to ring tomorrow morning and hopefully there will be one then', and I am saying, 'No, that's not what we've agreed'. So, we need to go back to the training and the responsiveness to patients.

[124] I completely accept what you say about the variation—where it is unacceptable, we are not here to defend it. We cannot have one solution that fits all, because everyone's practice population and needs are different. All practices should offer home visits if they are needed. I have heard what you are describing, though, where a mum cannot get her sick child seen, so she waits all day and then rings straight away at half past six. We know that it happens; we hope that it is infrequent. Everyone always remembers the bad experiences that they have. All that we can do is to keep working towards improvement, saying to GPs, 'Keep looking at your systems; keep making them responsive to patients' needs'.

[125] **Mike Hedges:** A lot of people would be very happy if you were to tell them, 'You can't have an appointment today, but you can have one tomorrow' rather than, 'Ring again tomorrow'. If you could make that change, you would take some of the pressure off A&E, you would make a lot of parents happy, and you would make a lot of elderly people happy. They want to see their GP, but, after two days of being told 'no', A&E is their only alternative.

[126] **Dr Jones:** And sometimes it becomes a crisis, when it did not need to be. Have you seen our 'sort it in one call' policy? We are happy to send that on to you. That did go out to all GPs. As I said, in 2009, we did have a little bit of flak from that, but we are going to develop it with our consultation document, because we do not want to be seen as obstructive. There is something else that you could all do for us, which is to remove other bits of unnecessary workload within the surgery that is clogging up the appointments to develop capacity as well.

[127] **Darren Millar:** We are going to have to move on now, I am afraid. Jocelyn is next.

[128] **Jocelyn Davies:** Thank you. Some of the points have been covered, actually. You mentioned the 'sort it in one call' policy. Can you tell us what the percentage is of GP practices in Wales that are still using this outdated daily scrum for appointments?

[129] **Dr Jones:** We would not have those data, I am afraid. Certainly, as I have said, if we can get some better network working across practices in a local area, where they can discuss their access arrangements as part of that—that is certainly something that we have suggested to the Welsh Government that it may wish to introduce—that would enable us to find out some of this information and to start challenging some of the views that some of our GP colleagues have. We are not here to defend the indefensible. We know that systems sometimes do not work for the best. Certainly, in my own 12 years in practice, I have been through four different appointment systems and we still do not think that we get it right for everybody all of the time. As I said, sometimes you hear a receptionist giving patients a really tough time, and you think, 'Oh God, that is really awful'. However, through these discussions

between practices—. I think that, if practices speak to each other and learn from each other, they are more likely to change. I do not think that they are very good when a manager comes in and says, 'You are not doing the job right'. I think that the immediate reaction is, 'I am doing fine, thanks' and to put the barriers up. So, I think that we have to do it through shared understanding and shared learning. We are bringing a consultation document out, which will be challenging GP practices as to how they are providing services. I suspect that we will get some comments back telling us exactly what we can do with our document.

[130] **Jocelyn Davies:** Yes, you did say—

[131] **Dr Jones:** We are there to challenge, however, and to say that we want it to be a responsive profession.

[132] **Jocelyn Davies:** Listening to your evidence today, you have spoken about your own practice and it does sound excellent there, although you do say that it sometimes slips back. However, we have no idea how widespread the good practice is, do we? So, the experience of the patients that you are seeing might not be everyone's experience, and, certainly, around this table, not many of us would be having the experience that your patients are having.

[133] **Dr Jones:** That is why I think that we need to get practices talking to each other. I think that they are so busy surviving at the moment that they do not have time to stop and ask, 'Is this working?' It cannot be working for them, so it probably is not working for patients. So, they need to have that stop. I would like to point out, though, that, when there is a crisis, such as the measles outbreak, the response from general practices, at a time when they were already really busy, was incredible. It is very sad, actually, that that has never actually been publicly recognised. The response of general practice to that crisis was enormous; I was very proud of my colleagues.

[134] **Jocelyn Davies:** I know that many Members in the Chamber here paid tribute at the time.

[135] **Dr Jones:** Thank you. We were very proud of how they took that on.

[136] **Jocelyn Davies:** There is a verbatim record, and many Members actually said how wonderful the response to that had been.

[137] So, perhaps we do not have enough information at a national level in order to understand the experiences of patients. I think that you would agree with that. What is your view, then, on the idea of ceasing the Welsh GP patient survey?

[138] **Dr Jones:** Although the survey has been ceased, the community health councils still go into the practices and do reviews of surgeries. On the patient survey, to be perfectly honest, I had to do one for my own revalidation, and you give it to 40 patients. Forty patients have seen me, on the whole they have chosen to see me, so, on the whole, the outcome is probably going to be satisfactory. Unless I have refused them something, on the whole, it is going to be satisfactory. So, I do not think that the patient survey was giving you the information that you want for this sort of inquiry. Community health councils go in and they seem to probe quite deeply. I think that that is something that should continue and I think they should carry on doing out-of-hours as well for the 24/7. David probably has more comments, because he has been more closely involved than I have.

[139] **Dr Bailey:** Certainly, CHCs are something that we have retained in Wales that should give patients more teeth and we certainly recommend that practices have their own individual patient participation groups, which can also feed back on appointment systems. You are absolutely right—the 8 a.m. scrum is not something that I would be prepared to defend; I do

not think that it is an acceptable way of providing services for patients and it is not a way, certainly not in the last two decades, in which I have provided a service for my patients. We guarantee that, if you phone up by 11 a.m., you will get seen by a doctor that morning—end of. It is easier to do that, in fairness, in a larger practice; we are a practice of eight doctors. It is slightly more difficult to provide that service in a single-handed practice. Obviously, single-handed practices, which many patients still prefer because of the personal care, sometimes have to be a little bit more flexible in the way they offer appointments. However, CHCs should certainly be able to provide the teeth to say, 'Your appointments system is not meeting the needs of your patients', and I would certainly not be prepared to defend any practice that does not—. What we think is a minimum ideal is that, when a patient gets off the phone to their practice, they know how it is going to deal with their problem. Whether that is an on-the-day appointment, whether it is an appointment down the road, whether it is a booked appointment with their nurse, or a phone appointment, they should know, when they put the phone down, what is going to happen. They should not be in a position where they have to decide, 'Can this wait until I have another go at the scrum tomorrow?' We do not think that is acceptable, and we said so very clearly in a policy that we published three years ago. There are regional variations. Probably in the M4 corridor, it is more likely that you see this advance access stuff, which, incidentally, was initially an English Government proposal, which, frankly, has been a disaster for general practice. I think it is much less common to see that in more rural practices.

[140] **Jocelyn Davies:** Do you know of any GP practices where you can just turn up—not phone, but just turn up and sit and wait your turn and you are seen?

[141] **Dr Bailey:** My practice. If you turn up at my practice, you give your name in, and you are put in the queue. We have an appointments list; you can phone to be put on it as well, but, if you come in, there will be a five-minute slot and you will see a doctor. At the start, it will be the duty doctor and, towards the end, when everybody has finished their routine appointments, we all pitch in, so we just call off the list. Sometimes, on a Monday, we do not clear that until 1.10 p.m. or 1.15 p.m., but, most days, we have cleared it by 12 p.m. Patient waits are probably, towards the end of that, maybe an hour, and, at the beginning of that, 10 to 15 minutes, probably. I think that is a reasonable way to provide services in a larger practice; it is not always possible in a very small practice, particularly with holidays and things, to do that, but, certainly in a large practice, it seems not unreasonable that you should be able to turn up and, if you felt you needed to get seen, you get seen.

[142] It is also worth pointing out that the GP contract mandates that GPs have to provide an urgent appointment when an urgent appointment is needed. You cannot just say, 'I'm sorry, I'm full'. If the patient says that their need is urgent, you have to see them. That is in the contract, and it is up to LHBs to monitor that. LHBs can also, because everybody has to publish their appointment systems in the practice leaflets, collate that information and monitor what the appointment systems are in their local areas. You might perhaps want to ask the local health boards if they have done that, and, if not, why not.

[143] **Jocelyn Davies:** Do you think that there is perhaps a temptation for patients to say that it is urgent—because you have to decide then, as the patient, if it is urgent—and then be seen?

[144] **Dr Jones:** Absolutely. That is the difficult call for a lot of patients. I think if somebody uses an urgent appointment inappropriately, it is up to the healthcare professional to educate them about that. I have seen patients who have waited four or five days to come to see me and I have asked, 'Why didn't you ring on the day?' and they have said, 'I didn't think it was an emergency', and I have said, 'No, but it should not have waited this length of time'. There are practices—there is one around the corner from mine, the Queen's Road Surgery, which is the King's Road Surgery in Mumbles, where you have to turn up and you will get

seen. We have a system whereby we are part open, part pre-booked on the day across the appointments spread, and, if you have an urgent problem, you can sit and wait. We will give you a rough indication of when you will be seen, and you choose whether you stay or come back.

[145] **Mike Hedges:** One thing we can all agree on is that we do not like the 8 a.m. scrum. I think that you have said that is your view, and it is the view of all the Members here, but we all know it is happening and it is happening a lot. How are we, or you, or somebody, going to stop it?

[146] **Dr Jones:** I do not think we can stop it. As I said, I have been through a number of different appointments systems in my time in the surgery, including just opening the doors and everyone queueing around the corner from 7 a.m. Now, we have some open on the day and some pre-booked on the day, and we will still see patients who turn up. I do not think you will ever get away from the 8 a.m. telephone ringing.

10:00

[147] My Health Online, which is a computer-based Welsh Government programme, enables online booking. That is not rolled out across Wales yet, but the IT systems in GP practices across Wales will all be one of two systems as of July 2015. I think that we have to have systems that are available to the needs of all patients—some prefer the telephone, some prefer to walk through the door, and some prefer to do it online, so we have to have a variety of things. However, I do not think that we will ever get away from the 8 a.m. scrum, if I am honest.

[148] **Mike Hedges:** I am sorry, when I mentioned the 8 a.m. scrum, I meant the fact that you ring at 8 a.m., and you get rejected at 8 a.m.. I have never known a receptionist—and I have checked this with my constituents—who has ever said, 'Is your case urgent or not?' The answer that you get from the receptionist is, 'No, there are no appointments today'— and that is by 8.10 a.m.—'because they have all gone'. That is the reality. How do we get across that, if someone phones up at 8.10 a.m., they can get an appointment, if not that day, then the following day, or the following day, rather than having to re-join the game? That is a problem; it affects large numbers of my constituents, who tell me about this issue more regularly than they tell me about almost anything else.

[149] **Dr Jones:** What we can do for you is that, since I have taken over the chair, I write a regular blog, and I will say that the outcome from here was a very strong message that, actually, that is not helping patients. Whereas I cannot force practices to make a difference, we will reissue our 'sort it in one call' policy, and our consultation document will be going out, and we will be pointing out the patient voice in that. I actually hear my receptionist saying, 'Is your problem urgent for today, because all the appointments have gone?', and I hold my head, and say, 'No, that is not what we said'. So, we need to do an education around the scripting of words as well, I think. However, I do not think that we will ever get away from it, and all that we can do is to keep pushing and saying to practices that they need to look at how patients can access their services.

[150] **Dr Bailey:** The other thing that I should say is that it is a contractual requirement of all practices to provide appointments for urgent cases. If that is not happening, that is actually an issue for the local health board to address. The local health board has monitoring and varying powers for the GMS contract, and if people are not meeting the GMS contract, then it is right and proper that LHBs should look at that. In my experience, that does not happen. We have tried very strongly to provide leadership and guidance from the BMA that that is an inappropriate way to manage services. I absolutely agree with you—we have never liked that, and we do not think that it is an acceptable way to provide services, and we have said so very

clearly.

[151] **Darren Millar:** I think that we have spent long enough on this 8 a.m. scrum, so we are going to move on. Julie Morgan has the next questions.

[152] **Julie Morgan:** I will go back to the core hours issue. As I understand from what you said earlier, under the terms of the contract, you do not have to offer appointments between 8 a.m. and 6.30 p.m.; you just have to provide a service in some way or other. Could you expand on what you mean by that?

[153] **Dr Jones:** The work of general practice is not just about offering appointments—there is telephone consultation work and there is home visiting to be done; as well as seeing patients, there is managing blood tests, there is managing all the administrative hospital letters, and so on, that come in, as well as running chronic disease clinics. There is a whole plethora of work that goes on within general practice that is more than just the appointments on the day, for the acute needs of the day.

[154] **Julie Morgan:** Do you think that this is clear enough in the contract?

[155] **Dr Jones:** Yes, absolutely; I think that it is crystal clear. Where practices are not providing that, as David has said, the health board should be monitoring that, which it is doing in our area. We have looked at surveys and questionnaires, and it comes in and it does verification visits of all sorts of things. However, we do think that it is crystal clear, and the health board should be doing more where practices are not meeting their obligations.

[156] **Dr Bailey:** Certainly in Gwent, where there is an agreement between the local medical committee and the health board, we have 5 As for access. That is about making sure that practices do not close at lunch time, do not have half-day closing, offer appointments up to, or after, 5.50 p.m., and offer appointments before 8.30 a.m.. Those sorts of things can be done by agreement. As I have said before, it is more difficult for a very small practice to provide that level of access every day, because that would basically imply a 55-hour or 60-hour working week for the individual doctor, if they were the only one who was there. It is much easier for larger practices, and it is not unreasonable that they should try to organise themselves to do that. However, the contract is absolutely clear. It is to provide 8 a.m. to 6.30 p.m. emergency services, and an appointments system that is adequate to meet the needs of the patients. That is the GMS contract that the LHB has to monitor, and it is for others, perhaps, to decide whether the LHBs are monitoring that adequately.

[157] **Dr Jones:** I think that it is fair to say that most of the health boards are working with their local medical committees to try to do some work around what is reasonable. Certainly, in my own surgery, we shut over lunch time for a short period, but that time is used by the reception team to ring back and respond to patients' queries. They also do the admin that has come in during the morning, and they address and make sure that the rooms are ready and prepared for the clinics of the afternoon. So, we are shut for a short period, because we are a smaller surgery and we are spread across two sites. I think that we have to recognise that we have to work on what is appropriate and reasonable. I would say that health boards are working with LMCs across Wales, I would say, from what we are hearing. Sometimes, we hear a little bit of angst as to what is being proposed, so we do know that this work is going on.

[158] **Julie Morgan:** Would you not consider it reasonable that more patients should have access to the 6 p.m. and 6.30 p.m. appointment slots?

[159] **Dr Jones:** I think that where there is a need, that is what you need to provide. You need to provide a service that meets the needs of your population; mine is mainly elderly, so

they value coming in in the early afternoon, because it is not dark as it is in the evening, they can get there on the bus route, and it is easy if they need to get to the chemist and the pharmacies are still open. So, I think that you need to have appointments available to meet the needs of your population, but every population will be very different.

[160] **Julie Morgan:** Obviously, for people who work, 6 p.m. to 6.30 p.m. would be an ideal time, and the percentage of appointments available at that time seems to be very low.

[161] **Dr Jones:** They vary.

[162] **Dr Bailey:** It is relatively small, but there is an opportunity for health boards to commission extended hours, and indeed they do, in my practice and across most of the larger practices in Gwent. We find that while the number of patients who work, as a total percentage of my practice list, is obviously quite high, the number of people who access services, such as the people around the table, is relatively small. The number of times that people who are not on medication who work full time access the GP, compared to the average of six, is relatively small, because the vast majority of our work is done with children, the elderly and the chronically sick.

[163] I attend a lot of these meetings and have done so for decades, and it is always interesting to note how many of the policy-making people are actually the people who are least likely to use the GP. I include myself in that. That is part of the problem. However, yes, I do think that we do have a responsibility to provide something for our working patients.

[164] Our working patients do not need the same number of appointments each as most of our elderly and chronically sick patients—nothing like. However, there is an argument for doing that. It is interesting that several local health boards are not commissioning any of the extended hours service. One of the benefits of that service is that, when you are doing it—we just do one night a week on a Tuesday, when we open until 8 p.m.—it puts a whole tranche of appointments later, as well, because you will tend to start later and do a longer surgery and you might start at 4 p.m. rather than 3 p.m. So, that does make a whole lot more in-hours later appointments available. Actually, our patients tell us that that is more than enough and many of the people who come to see me at 8 p.m.—and will be doing so tonight, because my last appointment is at 8 p.m.—I very much suspect, are my old, regular patients who could only find an appointment to see me at that time and will not be someone who is working. That, unfortunately, is part of the problem. The needs of working, fit and healthy people when it comes to seeing their GPs are relatively much fewer than those of the elderly, children and the chronically sick.

[165] **Aled Roberts:** Rydych chi wedi sôn nifer o weithiau am fonitro. Rydw i eisiau cwestiynu faint o fonitro sy'n cymryd lle. Rydym yn sôn am gael mynediad at ddoctor teulu. Roedd gennym nifer o achosion yn ystod yr haf lle yr oedd doctoriaid yn y gogledd yn defnyddio'r rhif ffôn 0845, ond nid yw hynny'n dderbyniol o ran y cytundeb. Ysgrifennais at Lywodraeth Cymru a'r ateb oedd mai mater i'r bwrdd iechyd oedd hwnnw, ond, eto, nid oedd gan y bwrdd iechyd unrhyw syniad faint o ddoctoriaid yn y gogledd a oedd yn defnyddio'r rhif ffôn hwn. Felly, a oes monitro yn digwydd?

[166] **Aled Roberts:** You have mentioned monitoring several times. I want to ask how much monitoring is happening. We are talking about getting access to GPs. We had many cases over the summer where doctors in north Wales were using 0845 phone numbers, which is not acceptable in terms of the contractual agreement. I wrote to the Welsh Government and it said that it was a matter for the health board, yet, the health board did not have any idea how many doctors in north Wales were using that phone number. So, is there any monitoring of this?

[167] **Dr Jones:** With respect to the 0845 number, I am not entirely sure what monitoring

there is going on with the health boards, because they do have access. There was an issue in ABMU health board where a practice was using a telephone answering service that was inappropriate and we went to the practice and said, 'No, you cannot do this'. The problem with 0845 numbers, from what I know in England, is that a lot of them were tied in for certain lengths of time on contract. So, as their contracts were coming up for renewal, they were swapping back to normal numbers.

[168] **Aled Roberts:** There were actually contracts that were entered into by GP practices after the change in regulations.

[169] **Dr Jones:** Right. That should not be, but we do not have that information. We would not have that information. The monitoring that goes on within general practice depends on which aspect of the contract that you are looking at. So, you will have monitoring of access, you will have monitoring of enhanced service provision, both the quality and the amount that you provide, you will have monitoring of vaccinations given, if you have signed up for that service, and you will have monitoring of your quality and outcomes framework. There are post-payment verification exercises and there is monitoring through community health councils coming into the practice. There is a whole plethora of monitoring that goes on by the health boards, both by coming in person to the practice and via surveys and questionnaires. Did you want to add to that, David?

[170] **Dr Bailey:** Basically, the contract suggests that you should not now be entering into new contracts for 0845-type numbers—numbers that cost more from a mobile than from a normal landline. The LHBs should have practice leaflets from every practice that they are looking after the contract for. So, they should have the contact number details and, frankly, it is the responsibility of the local health board to monitor that. Charlotte is absolutely right; there were a number of legacy contracts that had been signed for several years that have only just come to an end. One of the contracts that we run in my practice finished only about two years ago and we changed to an 029 20 number. That is what everybody should be doing and it is for the LHBs to monitor that. If they are not doing that, then, frankly, they are not doing their job.

[171] **Aled Roberts:** Do the health boards publish their monitoring information, because I could not find anything?

[172] **Dr Jones:** It is very hard to find any information on anything that has been published. We had a real struggle to find a lot of information from Welsh Government statistics. So, it is there, but, again, it is a bit like a needle in the haystack. That may be something that you will want to highlight. Transparency is something that we highlight all the time, around a whole number of issues, but particularly around the GMS contract. This is not why you are here today, but transparency regarding spend by health boards is something that we feel needs some significant improvement, and the Welsh Government has taken that on board and we are working with it on that.

[173] **Aled Roberts:** Tra yr ydym yn sôn am wariant, roeddwn yn gweld yn eich tystiolaeth bod bwrdd iechyd Betsi Cadwaladr yn gwario rhyw £12 y pen y flwyddyn yn unig ar ei wasanaethau allan o oriau. Sut mae hynny'n cymharu efo byrddau iechyd eraill a pam mae'r ffigur yn y gogledd mor isel?

Aled Roberts: While we are talking about expenditure, I saw in your evidence that Betsi Cadwaladr health board spends only about £12 per head per year on its out-of-hour services. How does that compare with other health boards and why is the figure in north Wales so low?

[174] **Dr Jones:** I did sit on the 111 task-and-finish group until it was recently handed back to the national unscheduled care report, and Dr Chris Jones did look at the spends across the

different health boards. I cannot remember how much it is per head, so I would have to get those figures again. What I would say, though, is that money spent on GMS out-of-hours care has not risen since 2004, despite the service demand increasing, and there needs to be a significant amount of investment into those services to make them fit for the future, particularly when 111 comes.

[175] **Dr Bailey:** I can expand on that a little bit. The figures vary from about £7 per patient to about £19 per patient. Charlotte's core point is absolutely correct, and that is that the spend on out-of-hours services since 2004 has barely moved from around the £30 million mark in Wales, and it is very difficult, obviously, to provide those sorts of services in a more rural area for that sort of money. North Wales, you would think, would be spending the most, but it does not; I think that it is Dyfed Powys that does. However, certainly, the level of provision in north Wales has left something to be desired, certainly in terms of the numbers of doctors who are on and the responsiveness of the service. There is a lot of evidence from the LMC over the last several years about the level of service that is being provided, and £12 per patient is a tiny amount of money for half of the area of Wales, really.

[176] **Dr Jones:** May I also say one thing about 0845 numbers? It has just struck me now, actually—I had never thought about it—that NHS Direct Wales is 0845 46 47. Is that free to access?

[177] **Aled Roberts:** No, it would not be then.

[178] **Dr Jones:** So, you know—

[179] **Darren Millar:** That is a fair point.

[180] **Dr Jones:** It just dawned on me when you said, '0845' and I automatically went, '46 47', because of my out-of-hours hat.

[181] **Darren Millar:** Yes, it is a fair point. Jenny, I am going to bring you in now on out-of-hours services.

[182] **Jenny Rathbone:** On this out-of-hours issue, my personal experience of rural north Wales's out-of-hours care was excellent, so the actual expenditure per head is not always the full story. In the old days, Dr Finlays used to do all the out-of-hours work for their patients themselves, and then GPs got together into some sort of collaborative arrangement, so they were on call on a rota basis. We now have 10 different service models. So, what do you think is the optimum model for out-of-hours provision so that patients can get the consultation that they think they need urgently—obviously, it cannot wait until the next morning by definition, in their minds. So, what, do you think, is the most appropriate model?

10:15

[183] **Dr Jones:** I am very glad that you had a good experience in north Wales because, actually, the north Wales out-of-hours service is the one where we have the greatest concern about the sustainability of the workforce. So, I am glad that you had a good experience when you needed to use it. For me, personally, I think that it needs to be delivered and run locally by GPs. That is what I think works, and if you look at those areas that are successful you will find that, in the main, they have been developed from previous co-operatives, as we used to be called. They have significant engagement of local GPs, and the local GPs developed the service. Where that works, it has professional credibility, and the services tend to be designed around the needs of the patient, but more investment is needed.

[184] **Jenny Rathbone:** So, what is actually impeding that happening? I appreciate that

there is a working group looking at this at the moment, but are there barriers to that in health boards? Are there particular GPs who want to protect a sort of private practice that they have set up, or what?

[185] **Dr Jones:** I do not think that there is much private practice going on in Wales, actually. We have private providers providing certain elements of the out-of-hours service, like the call handling, but that has purely been down to health board commissioning—that they were the right service provider. I think that it comes down to investment in the GMS out-of-hours service. If they had enough finances and resources to develop the service, I think that they could do an awful lot more.

[186] **Jenny Rathbone:** So, you are saying that the per-session pay is not sufficient.

[187] **Dr Jones:** It is more than that, actually. It needs to be the wider workforce, so that you are not looking just at GPs. You need to look at the nurses who are involved in out-of-hours care, advanced practitioners, paramedics, et cetera. So, we need to have a sustainable workforce. That is not just down to GP pay. One of the biggest critical problems for GPs doing it, though, if we are specifically looking at GPs, is around the indemnity payments. When I took on the role of chair of GPC Wales I reduced my practice commitments by two days, but I passionately love my out-of-hours service and wanted to carry on working there. You would think that working less on front-line medicine would mean that my indemnity insurance payment should reduce as well. In fact, it escalated and nearly doubled. Actually, it is prohibitive to carrying on doing some of this work if your insurance payments are that high. We have taken this up with the Welsh Government, through the 111 group, and, in all fairness, it is proactively looking at that, but we need to look at investment in the service because it is stretched too thinly. We could do so much more with just a little bit of investment. For example, we could have more community resource teams, enabling patients to come home from hospital and doing more in the community to prevent them from going into hospitals. They are available in variable amounts. District nursing services are not available 24/7 in every part of Wales. Even within ABMU until recently, there were three different models of district nurse provision in the different localities. If I had a district nurse whom I could ring and had confidence in perhaps doing a little bit more with the patient, we might be able to prevent that patient from going into hospital. When you do not have a district nurse there to help you to perhaps do a catheter, administer an enema or something like that, to keep the patient out of hospital, the only option that you have is to admit that patient into hospital. So, we need more investment within the service. It is criminal, actually, that it has not been invested in since 2004.

[188] **Jenny Rathbone:** That is one of the reasons for reconfiguring services in hospitals, is it not?

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

[190] **Mohammad Asghar:** Thank you very much, Charlotte, for being the chair of GPC Wales.

[191] **Dr Jones:** You are welcome.

[192] **Mohammad Asghar:** I am very pleased that you have been very informative. I have a classic example in my constituency. A husband goes to one surgery and the wife goes to another. Both are pensioners. The husband is very satisfied because he only sees two GPs practising in one surgery, but there are 10 and more in the other surgery. The wife is very dissatisfied with that because she sees a different doctor every time, and the timing has already been mentioned. So, there is a long list of problems there. Please look into this, because the patient wants to see the same doctor all of the time. As you said earlier, people

are living longer. Doctors do not change their posts or their practices; they are still there. So, patients like to see the same doctor all of the time, but it is not happening in the last practice that I mentioned.

[193] **Darren Millar:** Is there a point here, actually, about patient confidence in GPs, particularly in large practices? Obviously, there was an announcement across the border, from the UK Government, about the family doctor model being resurrected. Is that an issue in Wales?

[194] **Dr Jones:** I think that we have always been family doctors. I do not know about you, Dr Bailey, but I have always prided myself on being a family doctor, even if people disparagingly say, 'You are just a GP'. I hear that quite a lot from colleagues in the profession.

[195] With respect to continuity of care, I completely accept that, when you are an older patient or you have a chronic disease, you want to see the same face, or the same people within a surgery, so that there is a continuity element. When you are a younger, working patient, and if you were acutely unwell, for example, you probably do not really care which doctor in that practice you see, or nurse, as long as you see somebody who can sort your problem out there and then. There is always a fine balance. I think patients tend to go to the practice that suits their needs, and we are certainly seeing a bit more mobility, with patients actually moving practice to those they feel will suit their needs better. I am in a partnership of six; some work full time, others part time, and since I have taken this job patients say, 'Oh, I am so glad you have not left, but I can never get an appointment with you'. So, I work the system. I tell them to give me a ring and we sort it out, and that is lovely. I know that I am not indispensible, because, if a horrible accident befell me, I am sure that they would grow to love whoever comes in my place, but it is lovely to feel loved for that short period of time that they love me for. We accept that there is a balance between continuity and acute needs, and we are always looking at the fact that there is the younger working population, or those who just need care there and then, versus the chronic continuity. This is something that we are mindful of, and it is something that we try to highlight all the time.

[196] **Mohammad Asghar:** My question is on GPs working within emergency departments, and the question is: why do you think that there is not more widespread use of GPs in emergency departments to help deal with the unscheduled care pressures? Given your comments about capacity in primary care, how realistic is it that there will be an expansion in the number of GPs working in emergency departments?

[197] **Dr Jones:** GPs working in emergency departments is a skill and a specialty in itself. GPs want to be GPs. I actually really enjoy the cut and thrust of going into an emergency department, and I enjoy that sort of working, but I have to accept that that is not how the majority of GPs have gone in. It tends to be those who wish to work out of hours, and they do it, but we have a finite pot of GPs. Actually, I would rather they concentrated on making sure that other aspects of general practice are provided to a high level, rather than stretching and diluting them across a whole area of other roles.

[198] With respect to increasing the number of GPs, that is out of our hands, to be honest with you. That is a commissioning agreement between the Welsh Government and the deanery, and then of course it is about finding the students and the doctors to take those training places. It is out of our hands, but we have highlighted that we need more GPs being trained in Wales.

[199] **Mohammad Asghar:** I think we all agree that GPs are working very well, or very nicely, when there is an emergency, or some epidemic or some silly thing happens. Anyway, in the peace, at normal times, I think that things are not the same. That is definitely right.

There are a lot of problems. There is a long list of problems and we are inundated in our constituencies with people coming with complaints. I think NHS directors are very well aware of those problems anyway. So, it is not fair of me—

[200] **Dr Jones:** Certainly, as chair and vice-chair, we are really keen to address these problems. Unless we know that they are happening, we cannot do much about them. All we can do is keep encouraging general practices to look at what they are doing, and keep encouraging GPs to put patients first, which they do. It is just that they are workload saturated, and they simply cannot stop and stand and look to do what they want to do a lot of the time. If you have anything that you think we should take up at the national GP committee level, by all means just contact me. I am easily contactable; the world and his wife has my e-mail address and mobile number—or, contact the local medical committee and say, 'This has been raised. This is not acceptable'.

[201] **Darren Millar:** I have two supplementary questions here, briefly, from Jenny and Sandy.

[202] **Jenny Rathbone:** You were saying that they were workload saturated, but what is the ratio of GPs to patients in any given practice?

[203] **Dr Jones:** It depends on the patient list, does it not? It is roughly—

[204] **Jenny Rathbone:** What is the patient list to the number of GPs in a practice?

[205] **Dr Bailey:** The average size of a practice in Wales now is about 6,400 patients, and the average number of principals there is between three and three and a half. That has gone up gradually over time because people's working practices have changed; a lot of people who are retiring were working a full-time commitment, and a number of the people coming in are working a part-time commitment. So, the actual replacement is not like for like; it is not one for one. However, as to the average number of patients compared with the number of principals in Wales, you can pretty much work it out—it is about 1,700.

[206] **Jenny Rathbone:** So, less than 2,000.

[207] **Dr Bailey:** Yes. It is worth remembering as well that the chronic disease levels in Wales are 15% higher than in England, despite the fact that incomes are significantly lower.

[208] **Jenny Rathbone:** The average in London, as expected by the then PCTs, was 2,500. That was in an urban environment.

[209] **Dr Jones:** There is an enormous amount of work going on that is taking up appointments that does not need to be happening. Again, that would have to look at some of those unnecessary uses of appointments to free up time.

[210] **Sandy Mewies:** Very quickly, even if you get dozens and dozens of GPs working in emergency departments, I would assume that there is no point in their being there unless they have a pathway to refer through that is a slightly different pathway from the normal A&E very often. You cannot just have GPs; they must have somewhere to send patients.

[211] **Dr Jones:** Actually, the skill of a GP is usually to send patients home, because the patients that they tend to be able to deal with best are those that the casualty teams struggle with: the grey headaches and the bit of vague abdominal pain, not the cut-and-thrust, definite emergency or accident. It is the sort of grey-area patients, those in between, with whom they do not have the experience that we have. So, actually, we tend to reduce the number of tests that are organised through appropriate prescribing and, usually, we discharge home. If we

need to admit them, then we admit them in the same way that the casualty teams would.

[212] **Sandy Mewies:** Yes, but what if it was a patient who actually needed to go into residential care or needed more domiciliary care? Surely, you must have the ability to know where they can be referred to from there.

[213] **Dr Jones:** That can happen. You can use the knowledge that you have yourself of being a working GP, but you can also use the social workers and things that are linked to the department, or the community resource teams that are often linked to casualty departments. I think that we are slightly better versed in the wider use of healthcare professionals to support the patient, rather than thinking just about admission. We are much better than that. I would like to signpost you to have a look at the acute GP unit down in Singleton, as it has been extraordinary. Also, we have had GPs in the ambulance control regularly in Carmarthen—one of my colleagues does that, and they have hit their targets because, again, it is about ringing patients back, comfort calling and making sure that their needs have not changed. You actually find that you get a better use of ambulances through working together. However, having him there means that I do not have him for another piece of work somewhere else, so we are a finite workforce group at the moment.

[214] **Mike Hedges:** Very briefly, you work in Morriston with the co-location of out-of-hours GP services with A&E. Do you think that that model should be promoted throughout Wales?

[215] **Dr Jones:** Yes, where it can be delivered. I certainly think that where you are co-located, you need to use the co-location. I would say that not every area of ABM does that terribly well. I think that they could utilise it more in the Princess of Wales Hospital, and I certainly think that the relationship in the co-location in Neath Port Talbot is something that needs to be looked at by the health board. Singleton works very well, and, as I say, it has been a really heartening exercise; it has been great having that interprofessional dialogue where we are co-located—it is good fun, actually.

[216] **Darren Millar:** Should health boards directly employ GPs, to embed them in A&E departments?

[217] **Dr Bailey:** Yes, why not?

[218] **Dr Jones:** Again, if you directly employ a GP, there is no reason why not, but where you directly employ a GP, that is one fewer to be providing GP services elsewhere. Equally, however, we have to make sure that there are attractive options for GPs to provide services, however they want to do that. There are directly employed GPs in different parts of the Wales principality, and what I would say is that where they are being used as directly employed GPs, we need to use them to the best of their ability to make sure that they are value for money.

[219] Should they be within emergency departments? Yes, but let us make sure that it is the right GP for that, because I would not say that every GP has the skills to work in that sort of department. I certainly would not say that all GPs have the skills for the acute GP unit, for example. Where they have an extra skill, however, yes, let them use it. The Greenaway 'Shape of Training' review suggests just that: where you have a special skill, use it as well as providing general practice. However, anything that you take out that it is not core general practice means that you have less available to general practice.

[220] **Darren Millar:** The final question is from Julie.

[221] **Julie Morgan:** Finally, you have expressed concerns about the 111 service. Do you

want to say a little more?

[222] **Dr Jones:** I have not expressed concerns; what I have expressed is that it is a huge opportunity for Wales to get it right. The right solution will require the right resources, and it is a huge opportunity. It could work really well, provided it learns the lessons from England. I sit on the 111 task and finish group, and we have worked with them very closely on the model that has been proposed through that. We do not have concerns; what we would have concerns about would be if something were to be rushed in and a cheap option put in place that could potentially affect patient safety. So, building on the—

[223] **Julie Morgan:** Are you afraid that that is going to happen?

[224] **Dr Jones:** No, I am not afraid at all, because I have heard nothing about progress since the model that we designed and the standards that we designed to go with that were presented to the Minister. So, it is now over to the Minister and the unscheduled care board. As I say, it is a huge opportunity that could really work well for Welsh patients. So, fingers crossed, they will take on suggestions that have been brought through from the 111 board.

10:30

[225] **Dr Bailey:** The key is that the service is integrated. The mistake that they made in England was quite clearly that they separated the 111 service from ambulance controls and from out-of-hours units. So, they have very slow options—or no option—to get clinical advice directly. What happened was that they were using extremely risk-averse algorithms, and that drove demand right the way across the system and the whole thing fell over, until it was given back to GP out-of-hours co-operatives, with very little thanks from the Government in England, I have to say. The Welsh Government has learned much from that and it is trying to develop something that has co-location for emergency 999 services, the 111 service and the out-of-hours service. If you can do that in a constructive way so that you can give clinical advice quickly for the difficult cases, then there is really the potential to make that work well in Wales.

[226] **Julie Morgan:** Charlotte, you have been involved in the planning; do you think that GPs have had enough of a say in what the proposals are?

[227] **Dr Jones:** I represent the GPs of Wales; what I say goes. [*Laughter*.] I am only joking. To be perfectly honest, the all-Wales out-of-hours providers have had a say and we have had a say. We have represented the concerns of GPs. There will have to be a consultation when the final model is agreed, resourced and then put in place. GPs were very anxious about 111 when it was first suggested, because they could hear and see what was happening in England. The approach that the Welsh Government has taken in doing it properly and slowly and learning the lessons means that it has a much bigger chance of success. I hope that that will engage and bring not only GPs but all healthcare professionals on board, because we all need to be working with services.

[228] There is something that we need to be doing on a wider level in relation to public education regarding the plethora of services out there. We need to make sure that patients make the right choice for them and look more at self-care, which is a huge agenda in itself. However, once again, we have to have some honest conversations about the resources that we have available to deliver services and to meet what is needed rather than what is wanted as a convenience service.

[229] **Jocelyn Davies:** I just wanted to clarify a point regarding the data you have. Both of you have referred to urgent primary care; do you know what that ‘urgent’ means? Is that because people said it was urgent, or is it because it was not a pre-booked appointment? Were

they urgent calls?

[230] **Dr Bailey:** That means what ‘urgent’ means everywhere. It is a patient definition. Urgent calls going in to casualty are patient-defined, urgent calls coming in to general practice are patient-defined. It basically means ‘on the day’. The report that was quoted—

[231] **Jocelyn Davies:** So, it could be the 8 a.m. scrum? Could this be the people ringing at 8 a.m.?

[232] **Dr Bailey:** In those practices that are still misguided enough to do that, then, yes, but for most of us it is people who want an appointment on the day and who have not pre-booked it in advance.

[233] **Jocelyn Davies:** Okay. At least I know what we are counting.

[234] **Dr Jones:** It is not just appointments, but telephone consultations and home visits on the day. So, it is wider than that. It is urgent contacts.

[235] **Darren Millar:** That brings us to the end of our evidence session. We are really grateful for your help with our inquiry, and we will certainly follow up the ABMU study that you referred to in terms of the information that might be able to inform our inquiry going forward. Thank you very much, Charlotte Jones and David Bailey. You will get a copy of the transcript of today’s meeting, so if there are any errors from a factual accuracy point of view, you can correct them.

[236] **Dr Jones:** We will send you the information, as promised. Thanks for having us.

[237] **Darren Millar:** We are very grateful.

10:33

Papurau i’w Nodi
Papers to Note

[238] **Darren Millar:** This item on our agenda concerns the papers to note and we have the minutes of our meeting on 12 November 2013. I take it that those are noted.

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

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

the committee resolves to exclude the public from the remainder of today’s meeting and from the meeting on 26 November in accordance with Standing Order 17.42(vi).

[240] Does any Member object? There are no objections, so we will move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:33.

The public part of the meeting ended at 10:33.