Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 3 Rhagfyr 2013
Tuesday, 3 December 2013

Cynnwys
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Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

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 Ruth Hussey	Prif Swyddog Meddygol, Llywodraeth Cymru Chief Medical Officer, Welsh Government
Dr Grant Robinson	Arweinydd Clinigol ar gyfer Gofal heb ei drefnu Clinical Lead for Unscheduled Care
David Sissling	Cyfarwyddwr Cyffredinol ar gyfer Iechyd a Gwasanaethau Cymdeithasol/Prif Weithredwr, GIG Cymru Director General for Health & Social Services/Chief Executive, NHS Wales
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
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 09:01.
The meeting began at 09:01.

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. I will just deal with a few housekeeping notices. This meeting, of course, is bilingual, and Members and witnesses should feel free to contribute to its proceedings in the medium of Welsh or English, as they see fit. Headsets are available for those who require translation or sound amplification. I encourage Members and witnesses to

turn off their mobile phones and any other electronic equipment because they can interfere with the broadcasting equipment. I also remind people that the microphones are operated remotely, therefore nobody needs to press them. If there is an emergency, the ushers will guide us to the nearest appropriate exit. We have not received any apologies for absence this morning. We will now move straight on to the second item on the agenda.

09:01

Gofal Heb ei Drefnu: Ymateb gan Lywodraeth Cymru
Unscheduled Care: Response from the Welsh Government

[2] **Darren Millar:** I am very pleased to welcome back David Sissling, director general for health and social services and chief executive of NHS Wales; Ruth Hussey, the Chief Medical Officer for Wales; and Dr Grant Robinson, the clinical lead for unscheduled care. We are very pleased that you have come back on this particular issue at such short notice. We appreciate you making yourselves available.

[3] This session is a follow-up session to the previous session that we had with Welsh Government officials on 12 November. Unfortunately, we did not get to ask all of the questions that we would have liked to have asked on that occasion because the clock beat us. We particularly want to focus our attention in this session on primary care within the unscheduled care system and on the 111 service. We note the papers that you have also sent us in relation to the evidence that we have had previously, some of which touched on some of the issues that we will look at today.

[4] We will not ask for any opening remarks, as it a continuation session, but feel free to chip anything in, if you so wish, in response. Mr Sissling, in terms of practice opening hours and missed appointments et cetera, we heard evidence from the British Medical Association that suggested that the missed appointments record in Wales was worse than it was in other parts of the UK, most notably, I think, in Northern Ireland. It was suggested that the missed appointments percentage in Northern Ireland was around 6%, compared with 11% for primary care appointments in Wales. That seems to be a gulf. Does the Welsh Government have any understanding of why that is the case?

[5] **Mr Sissling:** First, I do not have comparative information for other parts of the UK. Our rates are as high as 11% in some practices. So, the first thing to say is that it is a matter of concern, and it is clearly the responsibility of the health boards and the practices to address that. It is an area that we are drawing to their attention as a matter for urgent action, and our insight into this is that there are a number of things that will help. We believe that the greater use of online booking, through My Health Online, will be of great assistance in this. There is general evidence that the use of online booking actually reduces the level of appointments that are not attended. There is also important evidence of good practice that we can adopt throughout Wales in terms, for example, of the use of reminders from practices, such as text reminders, which we are seeking to make sure are adopted throughout Wales. We are also doing an awful lot to share good practice across Wales, working with the General Practitioners Committee and health boards. I do not know whether colleagues want to add anything to that.

[6] **Dr Hussey:** At the heart of this is the fact that GPs and the practices know what the circumstances are that may have led to a person not turning up. So, I think that there is also some sensitivity about the circumstances, conditions and issues. So, it should also very much be looked at at practice level, to see what is happening and what the patterns might be. However, I think that there is good evidence that prompts, reminders and things like that can be helpful in reminding people that their appointment is coming up that day, if it is a few days

beyond when they first booked it. I think that that is also very much something that practices will be aware of.

[7] **Darren Millar:** You say that trying to minimise missed appointments is a focus of attention. We know that the evidence suggests that over 200,000 people who turn up to accident and emergency departments say that the reason that they have turned up is because they could not get a primary care appointment. We know that the number of primary care appointments that are being missed is between 550,000 and 600,000. We use the 11% figure. So, if you were able to reduce it by a third, that third could free up the 200,000 or so appointments that are turning up unnecessarily at an A&E department because of difficulty in accessing a GP. Online booking, yes; text reminders, yes; but do we have any evaluation as to whether they are making an impact at the moment? The text reminders have certainly been rolled out for some time now in some parts of Wales.

[8] **Mr Sissling:** Yes, it is clearly an issue of priority. There is something of a paradox that where there is appropriate access to appointments, we are seeing a significant number of people who, having made an appointment, do not turn up, which is clearly frustrating for us and for general practitioners, health boards and, indeed, I am sure, members of the public. At the moment, this is something to focus on. We need to pay more attention to this. We accept that this is an area to which we need to pay much more attention, because there is clearly scope within this to release capacity that could be used beneficially for other patients.

[9] **Darren Millar:** I assume that there has been no comparative work done between other parts of the UK at the moment at Welsh Government level.

[10] **Mr Sissling:** No, there has not.

[11] **Darren Millar:** Okay. Thank you. I now call on Sandy Mewies.

[12] **Sandy Mewies:** I just want to carry on with that for a moment, if you do not mind.

[13] **Darren Millar:** That is fine.

[14] **Sandy Mewies:** Online booking is great if you have a computer. This worries me slightly—and I know that you will not focus on this entirely—because, of course, a lot of the people who might forget an appointment, who may get a bit confused, may not have access to the internet or a texting service, much like many other people. I know that there are some people in their 80s who are much better than me at texting, and there are some people who would not touch texts with a barge pole in their 30s. How are you going to roll that out?

[15] Before I go on to my question, I want to say that I was surprised when the representatives from the BMA suggested that they had some evidence—although not a lot—that people who were turning up at A&E actually had been offered a GP appointment earlier in the day but because it had not suited, they had turned up at A&E. I was quite surprised at that. Do you have any evidence of that?

[16] **Mr Sissling:** No, not in terms of that latter point. As I understand it, you are saying that people who have had an appointment offered to them by their general practice have, because it was inconvenient—

[17] **Sandy Mewies:** Yes, or for whatever other reason, for example it was not quick enough. So, they then turned up at A&E.

[18] **Mr Sissling:** No, I have no evidence of that. I think that there is anecdotal evidence that that occurs. Obviously, that is one of the reasons why we want to make sure that the work

that health boards are doing is making their appointments systems as accessible and responsive to the needs of individuals as possible. We are encouraged by some of the work that some of the health boards are doing, which we are now working to disseminate to make sure that it is adopted across Wales. For example, Aneurin Bevan Local Health Board has introduced its five As, which are a means by which it can make sure that there is a systemic process focusing on issues such as access ratings, capacity, and its ability to respond to associated emergency admissions. Abertawe Bro Morgannwg University Local Health Board has an access forum involving the community health council and the local medical committee. So, there is work in this area, but we recognise that we need to make sure that there are improvements in appointments systems to make sure that they are better able to meet individual need.

[19] **Sandy Mewies:** I suppose that we cannot go on using anecdotal evidence. Anyway, I will move on quickly to my question. We heard evidence from the British Medical Association, and I think that it was quite robust in saying that health boards have the ability to hold GPs to account for delivering the contract. I think that it has already been said that you have to treat people with consideration, because for some people it would be a complete accident or there will be reasons totally beyond their control as to why they cannot turn up for appointments. I am quite sure in my own mind that there are people who just do not turn up. So, are they monitoring the whole contract strongly enough, and how would the Welsh Government assure itself that this was the fact? You will also be aware of the appointment of Professor Steve Field as the chief inspector of GPs in England. Has that sort of role been considered in Wales, or do you think that there would be any benefit of having someone in that role in Wales?

[20] **Mr Sissling:** The first question was about how health boards are holding practices that they have a contract with to account for delivery of the contract. That operates in a number of ways. They are focusing on a number of areas, such as the quality assessment framework. They assess delivery against the QOF measures, which represents spend of about £65 million across the NHS in Wales. They are also reviewing enhanced services, which is all the additional services nationally or locally. That is another area where spend is some £36 million, so these are big sums of money. They also do a primary care report each year for presentation to their boards, which allows them to look at issues such as access to primary care, measures of quality and the experience of patients. So, that is an important annual document and exercise in accountability.

[21] There are a very significant number of audits and checking exercises done through the shared service organisation. They will cover such matters as post-payment verification, to make sure that those are appropriate. They also cover processes of audit and assurance, counter-fraud services and patient registration. I have a list, which we would be happy to share, of a whole range of different checks that make sure that practices are being held properly to account.

[22] From our perspective, we receive summaries of these reports, and we pay a great deal of attention to them and consolidate them into national overviews and analysis. So, I think that there are the means by which we can say that health boards and we are holding the system to account. I suspect that there is more that we can do, as always, and we should always acknowledge that—we do not sit in a position of saying that everything is fine—but the mechanisms are there.

[23] The second issue—I might ask colleagues to respond to that—is really a question about the inspectoral regime that is applied—

[24] **Sandy Mewies:** Before you do, you have explained the process as to how health boards are meant to do it, and how you can monitor it. That is great. You can have processes

in place all the time, but how do you know that that is working? Do you know because action has been taken or action has not been taken, because it is not necessary? You can put all these processes in place, but how do you know that they are working? What evidence do you have that they are working?

[25] **Mr Sissling:** We would be examining these different reports, and we would be looking at benchmarks between the systems to make sure that we can do comparative analysis. In some cases, there is an absolute expectation. In some of these cases, these are audits to test against expected standards. This is not a process driven simply as an exercise of sequential steps; we are also looking at the outcomes. We are looking, for example, at the spread of the practices of the health boards in terms of their QOF ratings and the application impact of their enhanced services. For example, all the health boards have recently done a very vigorous analysis of their enhanced services, not just in terms of having them in place, but also what they are spending on them and what is the evidence of beneficial impact. They shared those with us, so that we have an opportunity to test out with them how well they are doing in those.

09:15

[26] **Dr Robinson:** To take the question about Professor Field and his appointment as chief inspector of general practice in England, we are watching that carefully because at the moment we are not quite sure how that is going to work. Professor Field has started to talk about what his regime might look like. We know that he has declared an intention—because he has a strong interest in service improvement, as well as inspection—to highlight examples of good practice, and to ensure that they are shared. As in England, in Wales we know that some of the best general practices are already doing many of the things around making it easy to book appointments, and to bring down the did-not-attend rates, so that it is easy to do the right thing if you are a service user. We are also keen to disseminate best practice, particularly in the areas that Professor Field has identified for development—integrating health and social care, as well as promoting better services for vulnerable older people, so that it is easy for them to use the service. We will be making an appointment of a primary care support lead to the 1000 Lives Plus programme, with the same intention, namely identifying and sharing best practice in primary care.

[27] The other thing to point out is that the care of older people is a particular focus area for the work that is going on through the new unscheduled care programme. Again, we will be watching to see whether there is anything that we can learn, but also, I think, hoping to develop some of the strong work that is already going on in Wales, so that we can also act as a beacon site in the United Kingdom. So, at the moment, I do not think that we have any plans to establish a similar role, but we will be watching carefully, to see what advantages there might be from it.

[28] **Mr Sissling:** Professor Field is an appointment within the Care Quality Commission, so it is within the construct of the inspectoral system. Our inspectoral system has Health Inspectorate Wales, which is currently reviewing its system, to ensure that it has the right ability to discharge its responsibilities. One area to which it is paying particular attention is primary care, and its ability, for example, to interact appropriately, with appropriate regularity, and with the appropriate skills, with general practitioners. That is a process that is ongoing. There are other points of assurance in terms of inspection; the community health councils visit general practices to ensure that they can discuss matters of interest to patients. Clearly, we deal with patient satisfaction issues with general practice, and, while not independent, as I was explaining, there is a very extensive system of audit, checking, and monitoring of general practice.

[29] **Darren Millar:** The GMS contract, of course, requires practices to be operating

between 8 a.m. and 6.30 p.m. Not all practices offer appointments during that period, because they have other things to do of course, on top of making appointments available to patients. Is that side of the contract being properly enforced, if you like, by our health boards here in Wales?

[30] **Mr Sissling:** It is a matter of great focus over the last few years, and will continue to be an area of priority. There is evidence of improvement in terms of the availability of appointments, and the number of practices that are operating, broadly, within their full contractual hours, and are offering appointments. So, the analysis in the report, I think, showed improvement in terms of the number of practices that are operating to their full contractual hours. We also look at those that work their full hours, or within an hour of their full hours, and that is at a current level of 68%; the recent information that we have is that—

[31] **Darren Millar:** But they are in breach of their contract, are they not? If they are not operating between 8 a.m. and 6.30 p.m., they are in breach of their contract. Why are we paying these people?

[32] **Mr Sissling:** We are working with the health boards, and we are examining all aspects of that.

[33] **Darren Millar:** This has been going on for years, Mr Sissling. What on earth is the Welsh Government doing to ensure that GPs are operating within their contract, so that their practices are open—or are operating—between 8 a.m. and 6.30 p.m., and that, where there is a multi-member practice, there are appointments available more readily, between 8 a.m. and 9 a.m., and between 5 p.m. and 6.30 p.m.?

[34] **Mr Sissling:** As you know, the information was showing very significant improvements, for example, in the availability of appointments in the latter part of the contractual hours—up to 94%—and there are indications that that will improve further. The path is one of improvement, and we are requiring health boards to be quite determined, and quite resolute, in using the contracts. You are right to say that the contract is there; it is a contract between two parties, and we should apply it with rigour and great precision.

[35] **Darren Millar:** This would never be allowed to happen between two contractual parties outside of the public sector, would it?

[36] **Mr Sissling:** I could not comment.

[37] **Darren Millar:** It seems pretty extraordinary that this issue has not been dealt with, given that GP access is clearly putting significant pressure on our unscheduled care systems.

[38] **Mike Hedges:** I was contacted by a constituent on Friday who cannot get an appointment after 5 p.m. Surely, somebody should be doing something about that. It does not involve a single doctor's surgery; it is a fairly large surgery in an urban area in Swansea, where there are at least four—probably six—doctors. Yet, 5 p.m. is the last available appointment. That is it. Will something ever be done, or is there an intention to do something, to ensure that people can get appointments at a later time, across all GP surgeries?

[39] **Mr Sissling:** There has been an improvement. As I said, 94% of all practices now offer appointments at least two nights a week in that latter part, after 5 p.m.—between 5 p.m. and 6.30 p.m. So, that is evidence of the attention that is being paid to that. I cannot comment on the particular circumstances of this particular case. It is wrong. I would accept that it is wrong and there should be availability. That particular matter should be taken up with the practice and with the health board to make sure that there is appropriate responsive action.

[40] **Mike Hedges:** You said 'between 5 p.m. and 6.30 p.m.' Do you mean within the full time of 5 p.m. and 6.30 p.m. or do you mean after 5 p.m. and anytime within that period? Will people be able to get appointments for the whole hour and a half, or will an appointment at 5 p.m. meet that 94%?

[41] **Mr Sissling:** It would, but clearly, our expectation is that it would not be that there is one appointment at 5.05 p.m. and then none for the further period. We know that there are fewer appointments as you get towards 6.30 p.m. but the clear expectation has to be that there are a reasonable number of appointments available during that time, rather than anybody just trying to satisfy a requirement. That misses the point of why we are doing this, which is, for a significant number of later appointments to be made available.

[42] **Mike Hedges:** Sorry; you used the words 'reasonable number'. What would you describe as a 'reasonable number'?

[43] **Mr Sissling:** I could not tell you a precise number, but it would have to be within the context of the appointments that are available during other hours of the day. We would not expect there to be any reduction over that last hour, or hour and a half.

[44] **Darren Millar:** What you are saying is that if somebody has one appointment after 5 p.m. and one appointment before 9 a.m. that, in your statistics, is considered a success.

[45] **Mr Sissling:** Not from the point of view of—. I have not enquired about precise numbers. I am happy to do so to make sure that when we say '94%', it means that it is a true representation. So, I am very happy. I would not offer that to the committee; that would clearly be wrong, to be quite honest. So, I would be very happy to make sure that, when we say that 94% of patients are offered appointments in that time period, it means what we would want it to mean. That is my expectation. It would be wrong to say anything other than that.

[46] **Darren Millar:** I appreciate that that is your expectation, but is that how these data are being recorded and given to you?

[47] **Mr Sissling:** I can check that for you. I am absolutely certain that that would be the case.

[48] **Mike Hedges:** Would it be possible to collect those data in half-hour blocks? So, how many are 5 p.m. to 5.30 p.m., how many are 5.30 p.m. to 6 p.m. and how many are 6 p.m. to 6.30 p.m.? My knowledge, only of Swansea, is that, you might well be hitting a very high number between 5 p.m. and 5.30 p.m. but, between 6 p.m. and 6.30 p.m. you would hit a much lower number.

[49] **Dr Hussey:** Perhaps I could add to that. If a practice books right up to 6.30 p.m., de facto, it then stays open quite a lot longer, especially if the patient who is booked in at the very last minute has a complex case. So, practices will clearly want to manage their workloads in such a way that staff know what time they actually finish for the day. We will look into exactly how many appointments there are, but I would expect practices to manage the flow of patients according to their staffing arrangements.

[50] **Mike Hedges:** My question was fairly specific: for the half-hour block of 6 p.m. to 6.30 p.m.—I am not asking how many people book in at 6.30 p.m.—how many are booked in for that period? I would guess, however complicated the problem, somebody coming in at 6 p.m. probably would not last much more than half an hour.

[51] **Mr Sissling:** No. We will do that. We will show a breakdown of those three time zones.

[52] **Julie Morgan:** I want to raise the situation of one of my constituents who, on a Sunday, was trying to access primary care for his daughter and was told that there were no appointments available in the out-of-hours service, so he was told to go to A&E. I was contacted by a furious parent yesterday to say that he absolutely understood why there were problems at A&E departments, because he was trying to get help at a primary care level, which was what was diagnosed was needed for the daughter, but had to go down to A&E instead. I wondered if you could comment on that.

[53] **Mr Sissling:** May I ask Grant to comment on that, because it plays to the issue of the whole system of unscheduled care?

[54] **Dr Robinson:** The first thing to acknowledge is that where there are problems with the out-of-hours service—and I think that we visited this territory briefly at the previous meeting—it causes pressure on A&E services, and that is to be avoided. Out-of-hours services and the new 111 line, which, as you know, has had teething problems elsewhere in the United Kingdom, is one of the areas of focus for the unscheduled care programme. The work stream that tackles that has now started to meet and will be working over the course of the next year. So, that work stream has to do a number of things: it obviously has to make it easier for people to use it, but it also has to investigate capacity. We think that the measures that health boards have put in place should mean that out-of-hours services are more robust this year than they have been on occasions in the past, but it is important to make sure that you minimise the occasions when they cannot cope. I am not in a position to comment on the individual circumstance, because I do not know about it, but we know that, in the past, there have been occasions when the out-of-hours service has become overloaded, and we need to make sure that that service and the paramedic service are bolstered in the future—I think that that is a general direction of travel that we would support—to make sure that hard-pressed hospital services are used when it is appropriate, but only when it is appropriate.

[55] **Julie Morgan:** This happened at 11 a.m. on a Sunday morning, so would it be normal that they could not offer any appointment during the whole of the day? Do you come across that very often?

[56] **Dr Robinson:** No.

[57] **Mr Sissling:** Without knowing the details, that sounds to me like a failure to provide an appropriate response to a quite reasonable request, so we would be very happy to look at that particular case.

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

[59] **Darren Millar:** Thank you, Julie. I call on Aled.

[60] **Aled Roberts:** I will come in after the next question, I think.

[61] **Darren Millar:** Okay; I call on Jocelyn.

[62] **Jocelyn Davies:** In response to Mr Hedges, you said that if appointments are not available after 5 p.m. in a practice or across Swansea, it should be taken up with the local health board. Who should take it up with the local health board? Are you suggesting that patients who ring the GP's surgery and who are then told, 'Sorry, we don't do appointments after—[*Interruption.*] This is not the first time that stuff has fallen down from the television; do not be alarmed.

[63] Who should take it up with the local health board? Should patients do that directly or

were you suggesting that Mr Hedges should take it up with the local health board? I wondered whether any statistics are collected on GPs doing home visits, because it seems that if you mention home visits, people say 'Oh, GPs don't do that anymore; they don't come out to people's homes anymore'. Are any statistics collected on GPs doing home visits?

[64] **Mr Sissling:** Let me answer the first part, which is that if a patient feels that they are not able to take forward a reasonable request for an appointment, clearly, the first port of call should be to check with the practice, because it is responsible for its registered population and part of the practice's responsibility is to make sure that it is demonstrably offering services that will meet the needs of the population. So, if a significant number of patients in the population are not having their needs met, clearly that would be something that the practice should take into account. So, that would be the first line of enquiry and pursual. The individual then could, of course, raise it with the health board, which has responsibility for making sure that a practice—

[65] **Jocelyn Davies:** I cannot imagine the conversation between the patient and the receptionist. You ring up, and they say, 'We don't do appointments after 5 p.m.', but I do not think that the patient is going to say, 'Are you meeting the needs of all the patients across Swansea?' It is just not going to happen, and that patient is not going to ring the health board to say, 'You know, I don't think that this practice is really meeting the needs of its population'. You cannot expect the patient to take it further or even to challenge their own practice or surgery in terms of whether it is providing services that meet the needs of the population across an area.

[66] **Mr Sissling:** No; I understand the point.

09:30

[67] **Jocelyn Davies:** Very few patients are going to be equipped to do that, or prepared to do that. Therefore, this may be something that should be systematically looked at from somewhere else, rather than it coming from the patient. I suppose that that is my point. Perhaps you could think about it.

[68] **Mr Sissling:** It is a really good point, and I accept it. However, at the same time, there should be a means by which an individual who did want to pursue the matter should be able to take it forward, rather than it just being an at-the-end-of-the-road process. Therefore, there is the CHC, and there are representatives, so I would not say that—and I am not saying that as just simply the answer—because the other line of that is that health boards should be, as they do, looking at the availability of appointments, and asking the practice to satisfy them that they are assessing the needs of the population and are appropriately meeting them. If that means that the population is saying that they want more appointments in the early morning, or that they want them to be balanced towards the end of the day, then they have to provide them. Therefore, the prime responsibility sits with the practice—the system—and we should not be reliant on individuals. However, it is right of course that, if individuals have a requirement, or they want to take things forward, they are able to do so.

[69] **Jocelyn Davies:** Yes, it is just that, in my experience, patients do not like to make a nuisance of themselves with their GP on matters like this, for all sorts of reasons. Perhaps you could think about the statistics on home visits.

[70] **Mr Sissling:** Yes, that is very helpful; thank you.

[71] **Jocelyn Davies:** May I just return to the issue of 'did not attend' for appointments? I notice that Sandy Mewies mentioned this earlier, but is this all anecdotal? Are we making up reasons in our own minds as to why people do not attend? If you have to book an appointment

at 8 a.m., I have a job to believe that you have forgotten to turn up to it by 11 a.m. I also have a job to believe that you would say, 'If I cannot come before 11 a.m., I will go and sit for seven hours in A&E'; I just cannot believe that either, but there you are. Do we know the profile of the people who do not turn up? I understand, as Sandy mentioned earlier, that some people might be confused. We heard from the BMA that perhaps some patients have mental health issues. Do we have any idea of the profile of the person who does not turn up? For all I know, it could be a failure of public transport as to why people do not get there, and it could be all sorts of things. Has any work been done just to look at who it is that does not turn up? As the BMA said, this missed appointments issue is having a huge impact on the ability of the GP to deliver services.

[72] **Dr Hussey:** I am not aware of an all-Wales look in detail, and, obviously, it would be quite difficult to get into the individual circumstances in each practice. However, it is an area that practices that are looking at better managing their flows, through the improvement methodologies, will look at: when people are coming, when they are not coming, and what the issues might be. Therefore, it may well be that, at practice level, they have an understanding of that, but I certainly do not have a detailed analysis of those patterns at a national level.

[73] **Jocelyn Davies:** Okay. It just occurred to me that, if it is generally people who are confused, sending them a text message when they might not even have a mobile— It just seems to me that, if you have a certain profile of people who do not turn up, then it does make a difference as to what strategy you use in getting them to turn up. Are these people who have to book two weeks in advance? I have a job to believe that you can even do that. However, if you ring at 8 a.m., or at 8.05 a.m., and you get your appointment for that morning, why are people not coming in that period of time? It seems to me that finding out who does not come makes a big difference as to what you will do later on. Therefore, has the Welsh Government considered any sanctions that it might take against people who fail to turn up, and who do not fall into these categories of being confused, or having mental health issues—people who just do not bother to turn up?

[74] **Mr Sissling:** In preparation for this meeting, we made some enquiries about the sense of who is not turning up for appointments. There is, clearly, some evidence, and it does merit some further work; you are quite right to say that we should do a major exercise to understand and really explore and get behind this headline figure of what is in the 11%. However, some of the feedback was that those who are not turning up are, sometimes, the most vulnerable, sometimes they are those who are in particular clinical need, and some of them have chaotic lifestyles. Therefore, we need to be sensitive to that and, as you said—it is your exact point—simply adopting an approach that says that, in a sense, there is blame in this would be inappropriate and, equally, sanctions may be entirely inappropriate. Therefore, at present, we do not think that sanctions are the appropriate way. I think that the way forward is for us, and for health boards, to undertake a fairly significant exercise to understand the different groups and the different reasons. As you say, there is a difference between somebody who simply does not turn up because, three hours later, something else has become more of a priority, and somebody who is very vulnerable who we should consider in a completely different light and probably needs us to reach out to them and support them.

[75] **Dr Robinson:** I want to pick up on your comment on home visits, because it is important. We know that the trend across the United Kingdom has been for GPs to offer fewer home visits as a proportion of the work that they do. That is partly a reflection that surgery visit appointments have become much busier. However, there is still a sense that people worry that it may be more difficult. So, the first thing I want to say is that GPs certainly do still do home visits. I know that for absolute fact. They tend to focus those, of course, on older and more vulnerable people who find it difficult to get into the practice. However, there may be occasions, if they feel people can travel—if they are younger and

mobile and so on and so forth—where they suggest that they visit the practice, where they might have visited in the past.

[76] The second point is that there is a return of focus on looking after people where they live, whether it is in their own home or in a nursing home, and improving the support, particularly, to nursing homes where there are older and vulnerable people. When we look at flow through hospitals, whereas in the past we might have assessed people in the hospital, we see that there is a growing realisation that it is important to assess them in their own home and to speed up the processes for doing that. That is a really good point to make. Getting to see people, particularly older and vulnerable people, in their home environment is an important way of improving care in the future. Some of it is going on already, but it needs a bit more focus.

[77] **Mike Hedges:** Does 'did not attend' mean that they did not attend the surgery, or does it mean that they did not attend the surgery on time?

[78] **Mr Sissling:** My understanding is that it is did not attend.

[79] **Mike Hedges:** At all.

[80] **Mr Sissling:** Yes. That is my understanding. Again, we can check the definition of that. Is your question about a situation where somebody comes in 10 minutes or a quarter of an hour late?

[81] **Mike Hedges:** If somebody arrives 10 minutes late because the bus was late and they had no control over that, do they count as 'did not attend' or are they counted as having attended?

[82] **Mr Sissling:** My assumption, but I think that we should check it out, is that every effort would be made to see them, but they might have to wait another 10 minutes while they reorder the priorities. That would be my assumption.

[83] **Jenny Rathbone:** When the leaders of the BMA GPC came to see us on 19 November, they told us that they, personally, were working to capacity and have very busy surgeries. I can well believe that. However, they also told us that the ratio of GPs to patients was 1:1,700, which seems rather low compared with other experiences I have had. I wonder if GPs are really working smart or whether they are trying to do everything themselves and are not sharing resources with other members of their primary care team. This is relevant before we leap into extending hours substantially.

[84] **Mr Sissling:** That is a really important issue. We heard the BMA GPC acknowledging that there is scope to bring best practice to bear. There may be areas where there can be improvements. We would certainly accept and support that and are already clear that there are things that can be done. The beginning of this is to get an appropriate understanding of demand and supply issues within the system and to make sure that that is something that guides and informs our work. There are areas that clearly will need to be paid attention to in terms of the entirety of the primary care team, not just the general practitioners. It is important that we do not see primary care as exclusively being about general practitioners. Some of the areas, however, are appointment systems within practices; both for GPs and for other professionals. That is to make sure, for example, that there is the right balance between the urgent and advanced booked appointments, and to look at the appropriate processes of triage. There is increasing evidence, which Ruth Hussey may talk about, on opportunities to use the telephone more, to make sure that there is an opportunity for patients to discuss things on the telephone. There are issues to do with the way in which receptionists manage flows of patients, physically, and in other ways, through the practice system. We are

guided by the Royal College of Physicians guidance in terms of same-day care. We are looking at changes to GP contracts that will support and reinforce this in terms of localities and best-practice reviews. Also, for example, My Health Online is another way in which we can use modern technology to help those that can access that. Would you like to talk about the telephone aspect as an example of this?

[85] **Dr Hussey:** The Royal College of General Practitioners has issued guidance on different ways of responding to patients' access, and there are a range of different methods that people are looking at. At the heart of it is understanding when people generally come and planning ahead, so that the time of day and the days of the week are anticipated, in terms of the types of need that people have. One example is a telephone system whereby GPs take the calls: people ring in and the GP rings back within a short period of time and deals with the issue on the telephone. That would not suit everybody; it requires a practice that has people who are able to do the telephone bit and people who are then able to see the people who have been booked in. So, you need quite a number of GPs. Some of it can be referred to a nurse or whoever else in the practice is appropriate. These are all different models that are being described and, at the heart of it, is matching what works best for particular local communities, because what works in a small practice in one area, compared to a large urban practice, would be quite different. So, what we need to do is encourage people to look at the capacity flows and to work out different methods that might work in those particular practices. The improvement approach is helpful in this regard, because we know that you can improve capacity and supply modelling through using improvement methodologies. So, there is a range of methods, and we want to work with GPs to look at what sorts of models might work in different situations.

[86] **Jenny Rathbone:** Going back to this issue of the ratios, in some remote, rural areas, 1:1,700 may be entirely appropriate, because it may have a very sparse population. However, what is your view about that being a low ratio in terms of what is deemed normal elsewhere? The ratio of 1:2,000 or 1:2,500 is much closer to the figure that I have been given to understand.

[87] **Dr Hussey:** We have to recognise that the work of a general practitioner and a general practice has changed so much in recent years. One million people in Wales have chronic health problems or a disability. We can do more and more things to support people with chronic illness, and so there is an expectation that all sorts of different support mechanisms will be in place and that consultations will increase. So, it is quite hard to say what the right ratio is. If you are living in a community where there is a very high level of chronic health problems and multiple health problems, the ratio, perhaps, will be a bit different to what it is in an area where people are generally in better health. So, it is quite tricky to say that there is a right answer. It is more important to me that we build on the locality modelling and the data that Public Health Wales has produced about GP profiles in local areas and get to understand whether we have the right mix of services for the needs of that population. The work that we are doing on the inverse care law, for instance, with two health boards is very much about asking, 'What are the needs in the population?', 'Have we got the right sort of systems and services that are reaching those who perhaps do not come at all at the moment?' or, 'Do we have the right support for those who are coming but need further interventions?' So, the real challenge for us is to get into the practice of asking, 'What are the needs and do we have the right set of services matched to the way that people want to use them in that local area?'

[88] **Jenny Rathbone:** Going back to the extended-hours issue, the spokespeople for the GPs who came to see us said that there would be various resource implications around your proposal to extend out-of-hours services and at weekends. One of the things that they raised was that they would need diagnostic services to be available if they are going to prevent that person from going to hospital. They need to know is it x or is it y. I wonder if you could tell

us a bit more about what your proposals are over and above what the service is already supposed to provide.

09:45

[89] **Mr Sissling:** We are looking at the issue of extended hours in three phases. I think that we are making significant progress with the first phase, which is to make sure—we discussed this previously, to an extent—that there is appropriate utilisation of the latter hour and a half of the contracted hours. So, we have discussed that and there is some work that we will come back to you on.

[90] **Jenny Rathbone:** Sure. We have covered that.

[91] **Mr Sissling:** We are up to 94% and we think that that will increase the next time we analyse the information. The next phase is the opportunity to offer appointments beyond 6.30 p.m. and we understand that there is a resource implication. We are currently looking at that in the context of a review that health boards have undertaken in respect of their enhanced services. We are assessing that with health boards and there is some further assessment that we want to do to make sure that it is appropriately adjusted and sensitive to local need. It will require some reprioritisation in that area. Clearly, we also need to specify and ensure that there is the right support for general practices to enable them to optimise the availability of that particular service.

[92] Next year, we will focus, in particular, on the opportunities to develop more services at weekends, which we think need to be increasingly seen within the overall unscheduled care system. The evidence is that if we can offer these Saturday and Sunday services increasingly, where it is appropriate to do so, it can have a significant impact on the ability to make sure that demand is appropriate and responded to in the right setting. Grant, would you like to talk a little about the Saturday service?

[93] **Dr Robinson:** Sure. It is obvious that people who have urgent problems have them all through the week, not just on week days. So, we are interested in exploring the best way in which we can work together with colleagues to deliver services across seven days of the week. That is not just general practice, but hospital services as well. There are some areas of the system that go to sleep a little at the weekends and on bank holidays and I think that we have to change that. That is quite a big change process, but there is now a professional will to look at that. That conversation is not just being had here in Wales, but across the United Kingdom. So, we are exploring the best way to do that.

[94] We have out-of-hours services, but as we have already heard, there are sometimes concerns that they become overloaded at the weekend. There is something about having a service that is as normal as possible, in respect of those urgent and emergency conditions, running without stopping. So, we will be looking at the best way to do that.

[95] **Darren Millar:** I call Aled, very briefly, and then Mike, very briefly.

[96] **Aled Roberts:** I will say this in English, because I do not know what the technology is like at the moment. Are we not kidding ourselves if we think that to increase the 94% operating between 5 p.m. and 6.30 p.m. and to increase the 11% operating after 6.30 p.m. is actually going to have a major impact? Surely, all that will happen is that the surgery will then not be open until 11 a.m., because that is what the evidence of the GP was last week: all you do is shift the hours of operation. You are still stuck with the hours that a GP will work and you are also facing a situation where you have a larger number now of GPs who work part time and GPs who take maternity leave might then decide not to work full time. It is a different pattern. In reality, we have a system that has not changed either in demand to that

change in provision, or in fact, the change on demands in the service. So, yes, you can come here in 12 months' time and say, 'Yes, we have raised it to 19% or 20%', but in reality, we all know that the system is creaking and we all know that, after 6.30 p.m. at the moment, you go down to A&E because the reality is that you have very little other option available.

[97] **Mr Sissling:** Thank you for that question. In a sense, I think that you have offered a guard against a complete preoccupation with appointments and the time of the day. It is important, because we know that there are parts of the population in Wales who would welcome the ability to have appointments beyond working hours. It is right that we try to make our services responsive to individual need, rather than saying, 'This is it; take it or leave it'.

[98] The bigger issue is about the way that primary care, in its entirety, shapes up to the challenges in the way that your question suggests over this year, next year and in coming years, not in some future horizon, but something more immediate. That is why, for example, we are looking at our locality networks whereby GPs and others in primary care can work in a very collaborative way and can take more responsibility for understanding and managing demands, be it unscheduled care or aspects of chronic condition care, which should become increasingly planned, or other areas of care, which can be defined as care pathways, and they can bring to bear their collective support and areas of specialist expertise. They can enjoy a different relationship with the hospital sector because we should not see primary care as being a separate entity, dislocated from the hospital sector. The hospital specialists and general practitioners can work very productively together, and we can look at the patient experience that is not defined by these movements at times in an episodic way across different parts of the system. So, that is where the Minister is very keen to see changes, which really are quite significant in terms of the way that primary care plays the role that it can, using those extraordinary expertise and skills that sit in primary care, where there is continuity of contact with the population, so that we can see it properly as an area that can understand population needs, manage demand and provide first-rate services.

[99] **Mohammad Asghar:** Disease and sickness never make appointments. They come straight away and the individual will need care straight away. Access to a doctor's surgery is not possible and then, as you ring the surgery, the doctor is not available to be contacted on the phone. Ruth said earlier that you can make and get an appointment by telephoning. It is impossible to speak to a doctor if you get symptoms of a sore throat or diarrhoea. That is problematic. They are small diseases; we are not talking about chronic diseases. We need emergency care when a child or a person is sick. Straight-away, attention is needed, and that is not there. Twenty years ago, it was there. Even though you just mentioned the resource implications and so on, funds have increased, but the service has gone down. The health service is definitely not bringing the real service to the patient who needs it at a particular moment, particularly the straight-away service or the emergency service. GPs are totally inaccessible these days. What is the Welsh Government doing to improve understanding of the experiences of patients trying to access urgent appointments? Given that data on demand for GP services are not routinely collected, what is the Welsh Government doing to resolve this situation? Finally, are GPs doing enough to understand the experiences of their own patients in trying to access urgent appointments? They are all questions for whoever can answer them.

[100] **Mr Sissling:** I will start. I am sure that the others will add their comments. I will look for confirmation, but for a patient with an urgent clinical need, the general practice is obliged to give a response within 24 hours.

[101] **Mohammad Asghar:** It is too late then because if there are symptoms in the throat it will get worse in 24 hours. If you see them straight away, you save money and everything.

[102] **Darren Millar:** This issue was raised with us last week. We were told by the British Medical Association that a patient has to say that it is urgent in order to access an urgent appointment and to trigger this response where there is an obligation. I do not think that patients understand that, necessarily. Sometimes, they do not know whether their situation is urgent or not. It is a judgment call for them, and they do not know that there is always an obligation for their GP to see them if it is urgent. What are we doing about that kind of thing?

[103] **Mr Sissling:** That may be a matter of better information and communication to make sure that there is that awareness. Within the context of that contact, clearly the outcome—and this is not the responsibility, simply, of the individual, but also of the health service in responding—is to determine the clinical urgency of that particular call. It should not be a question of the patient using some word that triggers a certain response, because that is entirely unreasonable. There should be a discussion of the symptoms and the experience of the individual, where an appropriate judgment is made. It should not be a matter of 24 hours if the need is immediate. If the need is immediate, alternative steps should be triggered to meet an immediate need. I suppose that what I am saying is that there is, within the system, an obligation on the practice to provide a very quick response if it is clinically demanded. That may be within minutes rather than 24 hours. If somebody phones up and is clearly having a very serious clinical experience then that needs to be responded to immediately.

[104] **Mohammad Asghar:** Normal practice is that, when you ring the doctor's surgery, at the other end of the phone is a receptionist and the answer is, 'Phone after 5 p.m.' and that is too late. So, you ring at 11 a.m. and then after 5.30 p.m. is too late.

[105] **Darren Millar:** Okay, I have two Members who want to come in. You can both ask your questions, Sandy and Jocelyn, and we will take a collective response.

[106] **Sandy Mewies:** My point was much the same as Oscar's, actually, because one of the problems is that, when you ring your doctor's surgery, you speak to a receptionist. I have had experience of several GP practices over the years. Some were good, but some would not let you in to see the doctor if their lives depended on it. It is a fact. I happen to have a pretty good GP practice at the moment, but there is a flaw in the argument, is there not, because the person whom you speak to, telling them your symptoms at 8 a.m., 7.50 a.m. or later on, apart from having to analyse yourself whether you are really ill, and I think that a lot of people do that, and ask themselves, 'Am I really ill enough to be doing this?'—

[107] **Darren Millar:** Can you be brief, Sandy?

[108] **Sandy Mewies:** The point is that it is a receptionist. What qualifications do they have to do triage?

[109] **Darren Millar:** Very briefly, Jocelyn.

[110] **Jocelyn Davies:** That was the point that I was going to make. I am not discussing my symptoms with the receptionist, to be honest. Who does that?

[111] **Sandy Mewies:** Exactly.

[112] **Darren Millar:** Also, the receptionist is usually on the front desk in full view of other members of the public. Jenny, you wanted to make a point as well on this.

[113] **Jenny Rathbone:** My question is: to what extent has the population lost the capacity and the knowledge to self-medicate? Oscar was mentioning sore throats and diarrhoea. Why would anybody who has those conditions, unless they have some other underlying condition, need to see a doctor at all?

[114] **Dr Robinson:** That is a really good question, with quite a lot packed inside it, actually. The first thing that I wanted to say is that, compared with 20 years ago, we are delivering a very different service, so we can keep people alive when we simply had no way of doing it previously—20 years ago, the treatment for a heart attack was, 'Go to bed and take an aspirin'; now it is to have a balloon blown up inside an artery in your heart. That has to be delivered completely differently, so we are in a different world, and the agenda that we had set for GPs, which I think does need to change a little, was to manage disease and to get the quality markers right, and that has been a complicated agenda and it has been a busy time for them to deliver it.

[115] So, where do we go now? The first thing to say is that today, in Wales, you can get telephone advice from a GP, but not from every general practice surgery. So, some GPs will be doing this. I think that there is common ground between me and Welsh Government and the profession that we can do more within the existing resource to change systems of care. That can be challenging, if you are a single-handed GP, but, if you are in a big practice and you have a few people who are interested in this—several of our big practices have had a crack at this, with some success—you can introduce different systems of care. However, the point about the receptionist is quite important, because then it becomes important that you are working as a whole team. The receptionist is part of that team, the nurses are part of that team and the doctors are part of that team. It is about getting them to work smoothly so that it is easy to get through. I completely hear what you are saying about how, sometimes, it can be difficult and there can be a perception, real or imagined, but often real, that the receptionist is more of a barrier than a route in. Clearly, it should not feel like that. What it should feel like is that you are quickly being diverted to the right place, so that you get to speak to someone who can help you. That might not always be a face-to-face meeting, it might be on the telephone, but you should be able to get the advice that you need. If you cannot get that, you will tend to go somewhere else; we know how people behave.

[116] The final thing that I wanted to say was that the point that Jenny was making about skilling up people to look after themselves is quite important. That is not meant as a criticism of people who feel that they need the service, but I think there is probably more that we can do to help people to look after themselves. We know that, in rural communities, people can be amazingly self-sufficient—perhaps sometimes a bit too much—and, in urban communities, that tends to be a bit less the case. So, you then have to ask yourself how you can do that by offering people the information that they need. There is some success already on that. We know that the NHS Direct website gets around 3 million hits a year, so, despite the reservations that people around this table have, quite rightly, about the challenges around using electronic media, there are big opportunities there to help people—sorry, I will wind it up, Darren—and also to tool up people who have chronic conditions so that they can look after themselves when they deteriorate. Again, there are some great examples, particularly for chest conditions, of people doing that already.

[117] **Dr Hussey:** I would like also to remind everyone that planning healthcare encompasses other health professions, such as pharmacists, and so we are currently developing the common ailments scheme. It will be really interesting to see how that is evaluated for the minor conditions that people can go to their pharmacist for advice on as well.

10:00

[118] **Darren Millar:** When is the evaluation going to be done on that?

[119] **Dr Hussey:** It is only just starting to roll out. It is being tested in two areas. It is another example of trying to innovate, testing, and carefully working out whether it does meet

different needs with regard to the common minor illnesses.

[120] **Darren Millar:** Aled, I am going to come to you next.

[121] **Aled Roberts:** May I just move on to whether health boards themselves are doing enough to actually help GPs to avoid unnecessary emergency admissions? Paragraphs 3.28 to 3.31 of the auditor general's report talk about failures as far as the ability to obtain urgent advice from consultants, and the fact that rapid-access clinics are patchy as far as their provision is concerned. What is your overall view of these issues as far as Wales is concerned? Clearly, the evidence that we had is that not enough is being done across the board, really.

[122] **Mr Sissling:** I think that we are doing significant work, but we need to go further and faster. I will ask Grant to talk about some of the areas where we can do more and build on what we have already done. I think, with my response to the committee after our last attendance, I gave some examples by health board of the schemes and initiatives that are in place across Wales. Each health board was able to describe some programme of work or some project; they are not comprehensive yet, and they need to be. Some of those are to provide opportunities to divert and deflect care into alternative settings away from the front door of the hospital, and many of them were evaluated as showing a very positive impact. So, there is significant progress. Grant, do you perhaps want to talk about where we would like to see this move with pace and rigour in the future?

[123] **Dr Robinson:** There is a hard side and a soft side. There is an improved focus through the contracting arrangements on unscheduled care, which we need to make the most of. Some of this, though, I think, is about working together with general practitioners to feed back the information about what is happening with their patients. Given that the IT systems have historically been in different places from the practice systems, the hospital systems and the social care systems, it can sometimes be difficult to know where your patients are, but there are ways to feed that information back. Health boards are piloting that now, using the locality clusters of GPs to get them together and say, 'This is what is happening to your patients', and then working with them to identify opportunities to avoid admissions. There is mixed evidence about the ability of GPs to influence the use of unscheduled care services, but there is no doubt that there are specific areas where you can do something. I mentioned earlier that, if you have someone with a bad chest who does not have a rescue pack and has not been taught how to use it, then that is an opportunity. You can look at admissions of people with chronic airways disease into your hospitals to identify opportunities to do that. We know that there are opportunities around end-of-life care. Not everyone at the moment ends their life in the place that they would choose to: sometimes they end it in hospital when they would prefer to end it at home, or in the place where they usually live, and, again, there is great interest in that, because the best general practitioners recognise that as an issue and are working to resolve it. So, there are definitely areas where you can make an improvement, but that has to be on the basis of the evidence. We can do more, and health boards can do more, and are doing more, to feed back that information to allow people to develop a customised approach, based on the opportunities that exist on their local patch.

[124] **Aled Roberts:** You mentioned sharing of information. Are you aware of instances where health boards are actually introducing protocols where information cannot be shared?

[125] **Dr Robinson:** I am not sure what your question is touching upon, but, in general, the direction of travel is to improve the sharing of information so that you are opening this up, because that information has been quite siloed, historically. I think that the intention is to develop information based around service users rather than around the service delivery system, if that makes sense. So, if there are examples of people reinforcing existing silos of information, we would be interested to find out about it, get into it and work with them to

change that.

[126] **Aled Roberts:** Okay. I will drop you a line on one case I came across last week. May I just move on then to community-based services? The BMA gave us some evidence that GPs were having to admit people to hospital because they were unable to access nursing services in particular within localities. Do you have any views on that evidence?

[127] **Mr Sissling:** Obviously, we would want to understand more about the evidence. I think that it is fair to say that we enjoy a good relationship with the BMA and the General Practitioners Committee, so there are opportunities for them to raise issues with us directly or with the appropriate health board. So, the first thing to say is that we do work through issues in a very constructive way, I think, with professional bodies.

[128] The second thing is to again reinforce the information that we sent, which does demonstrate that there are alternatives within health boards, which need to be made more general, that would provide an opportunity to access community-based teams, whether nursing, allied health professionals or social care, or, increasingly, a combination of those.

[129] The further thing to say, looking ahead, is that we are putting an awful lot of emphasis on our locality networks. We have currently just over 60 endeavours created where GPs, nurses and pharmacists can come together to plan services for their populations, understanding their needs, so that the kind of question that, in a sense, is raised by this can be responded to by the professionals working in the community to make sure that the services are developed and refined to meet the needs of those particular communities.

[130] **Aled Roberts:** We also received evidence that some of the accident and emergency departments, in particular, were not well suited to dealing with the increasing numbers of elderly patients and that there were skills that might be more tuned in. Mention was made of particular pilot projects in particular health boards where, perhaps, gate keeping occurred. Are you able to expand on that and say where we are?

[131] **Dr Robinson:** Sure. It is a feature of most plans this winter, but it is also a spur to a change in the system generally, to have an improved focus on older people, not just at the front-end of healthcare systems, but throughout them. The growth is undoubted in relation to the admissions of older people, with 6% more having been admitted to hospital in just the last three years, as the audit office report points out. There have been quite big changes. So, there are lots of older people and more people who have problems with memory loss and we need to build services around them. If you place yourself in the position of someone such as that and imagine yourself in an A&E department or on a hospital ward, it can be quite a frightening environment, it can be difficult to orientate yourself and difficult to know what is going on. So, there are bags of things that we can do.

[132] Some of that is reflected in discrete plans such as the frailty assessment unit at the front-end of Morriston Hospital, which should help it to offer a better service to older people. I know from my work in Aneurin Bevan Local Health Board that putting frailty care doctors at the front door, which is happening this winter, is an increasing focus. So, the two catchphrases that we have around this are that, at the front-end, where people do become unwell—and there is clearly stuff that you can do before that—and need to be considered for hospital admission, quite often the system is designed to just admit them at the moment, and so assessing to admit is a very important concept. As I said earlier, discharging to assess rather than trying to assess people in a quite alien hospital environment is another important thing. However, those are not small things to accomplish and we need to re-engineer the system around service users and encourage people to see the service through the eyes of the people who use it. Again, there is fantastic best practice, which we will be aiming to spread and promote in this area. I was with colleagues from Wales at a meeting in London recently,

where we were sharing experience from across the United Kingdom. There have been some fantastic pilot schemes, particularly in Sheffield, and we are working with the people who did that work to spread that in Wales.

[133] **Darren Millar:** The clock is against us, but we want to cover some territory on the NHS 111 and NHS Direct services just for a few moments, if that is okay. However, I have one final question on the care of the elderly. First, to what extent is the NHS working with the care home sector to ensure that there is access to a GP for residents in care homes, whether nursing homes or residential care homes? Secondly, does the bed capacity within the care home sector have the ability to relieve the pressure on beds in our hospitals, as flux and flex capacity, particularly in the winter months?

[134] **Mr Sissling:** The answer to the first question is 'closely', as you would expect. So, health boards are working with the care home sector to understand capacity, because it changes, and also to agree protocols and pathways by which there can be flows of patients where it is appropriate to do so. It is particularly significant at the moment. The health boards' winter plans take full account of nursing home and residential home capacity. The impact of any closures or reductions in capacity are felt and need to be addressed, so there is a very close relationship, almost on a daily basis if not weekly basis, with health boards advising us on potential possible changes in the capacity of the care home sector, and taking action where appropriate to respond to that. So, it is a very important relationship; we see it as part of the system, rather than something that is beyond our reach.

[135] **Darren Millar:** What about GP access? If a resident in a care home needs a home visit, for example, the anecdotal evidence suggests that that can be difficult sometimes for a care home to arrange, so the default position is that they send them to A&E. Is that something that—

[136] **Mr Sissling:** We are paying attention, because the responsibility of the practice to its registered population extends equally to those in a care home, so there should be no distinction. We and the health boards would be interested in areas where that is not working smoothly.

[137] **Julie Morgan:** Moving on to the 111 service, why is it taking so long to roll out and what is the exact timetable for it now?

[138] **Mr Sissling:** I will ask Dr Robinson to respond.

[139] **Dr Robinson:** As you know, we are creating the new programme at the moment. We have had a first meeting of the taskforce that has picked up that work. Dr Chris Jones, who had previously worked in this area as a member of our steering board, is fully engaged in the work that we are doing around this. The short answer is that we want to get it right. We know that some of the things that tripped up the service in other parts of the United Kingdom were training for the people who were delivering it, getting the skill mix right between non-clinical call handlers and clinical call handlers, and there is a sweet spot there where you can afford it, but you are also giving people the right advice and you have enough access to nurses.

[140] The other key piece of work, which is going to take a few months to put in place, is developing proper directories of service in each health board area and the localities within health boards. There is an argument that says that they should be there already, and, of course, they are to a certain extent, but it is about having proper comprehensive directories of service that people at both ends of the phone when you are making a decision about what to do can have access to. We also want to be ambitious for the future, so we are looking at ways to give the 111 service the ability to make appointments directly into the hospital service or the in-hours GP service. That is definitely a direction of travel. That will not be done quickly or

easily, but having that within a small number of years, if not within the next few months, is a place we would want to go.

[141] We are expecting to deliver this within a year or so, so the timescale that we have for it at the moment is spring 2015. However, the detailed timeline will be an early piece of work for that taskforce to create. We will be happy to provide information about that as we go along.

[142] **Julie Morgan:** When it is rolled out all over Wales, will there be more developments after that? Is that what you are saying?

[143] **Dr Robinson:** Yes. We want to get it as right as we can when we start to roll it out, but there will be some kind of phased approach around this, partly because of where we want to go to with this kind of transparent access, so that it is really easy if you are a service user to get into the system. That probably cannot be done quickly, but we need to do it.

[144] **Julie Morgan:** What will it deliver that is not currently being provided?

[145] **Dr Robinson:** The first thing to say is that there will be much closer connections between the existing NHS Direct service, the 111 service and GP out-of-hours service, so that hopefully, within a fairly short space of time, it feels like you are coming to the same bunch of people who are going to help you, and direct you rapidly to where you want to go if you are trying to make contact with a service when you cannot get through to your in-hours general practice. We would hope that there will be much closer links between the way that healthcare and social care are delivered, so that you do not have a further period of time when you have to wait for those links to be made, and we can do that through the directory of service. The proof of the pudding is whether people feel that they are getting the help that they need. We can learn from some of the early pilot work in England, where they had some very good feedback from service users, but we know that, when they scaled it up, there were some problems. We would want to learn from that.

10:15

[146] **Julie Morgan:** What exactly is the difference between NHS Direct and 111?

[147] **Dr Robinson:** The intention in Wales is to build that in to the same approach, so that it is less confusing for service users. There is a suite of things that NHS Direct does at the moment—there is the website, the liaison with ambulance services and clinical triage—and we would want to build that into the same desk in future. Does that make sense?

[148] **Julie Morgan:** I am not quite certain as to what 111 provides that is—

[149] **Dr Robinson:** The honest answer from me is that I cannot give you a completely certain answer about that at the moment, but we know what the potential is and we know that we need to plot the path forward quite accurately over the coming year. I can give you a general sense of what it is going to be like, and, as the work stream gets that detailed timeline, I will be able to answer the specific questions that you are asking about what you would be able to see and when.

[150] **Julie Morgan:** Will you send us a note about the detailed timeline?

[151] **Dr Robinson:** I will be happy to do that.

[152] **Julie Morgan:** What about the cost? How much will it cost?

[153] **Dr Robinson:** Again, I cannot give you a detailed answer on that at the moment. We know that there is not much more money to go around. I think that any answer that requires huge amounts of extra investment to deliver will be a problem. In fact, David and I were discussing where we are going with this yesterday and there may be some business cases around this as we move forward, but it will be a responsibility of the service—working with Welsh Government—to make sure that we go through that in the most professional way possible. We think that, as a general principle, a bit of judicious investment in the upstream part of the system should pay off downstream. That is what we would be looking to do.

[154] **Julie Morgan:** Finally, it seems that the rate of abandoned calls to NHS Direct has increased. Do you have any explanation for that?

[155] **Dr Robinson:** Again, we have been discussing this, because we have noticed the same thing. I think that a part of this is the fact that, when you go through the NHS Direct process, there are routes that are identified for you. It will say 'If you want information about seasonal flu and how to get vaccinated, listen to the following message'. So, people may drop out as they are going through that and those will be counted as call abandonments.

[156] In general, I think that the challenge that we need to get a much clearer idea of what it is like for a service user to experience the system is a fair one. It is probably also the case that, within those numbers about call abandonments, there are some people who got the information that they wanted and dropped the call at that point. However, I cannot tell you what proportion that was.

[157] **Julie Morgan:** It is increasing, however.

[158] **Dr Robinson:** The number of abandoned calls is increasing, but we know that the demand for the service is also increasing, so it is about understanding what service users want to get out of it and delivering that as closely as we can.

[159] **Darren Millar:** It is the ratio of abandoned calls that is increasing though, is it not?

[160] **Dr Robinson:** Yes. I am not sure whether that is because people are finding the information that they want or whether—the worrying alternative—they are getting fed up because it is taking too long.

[161] **Mr Sissling:** Information that I have just received in the last couple of days—obviously we are concerned about this—is that they are putting more information into the opening 30 to 45 seconds and, because there is more information and reference to websites or to other bespoke services, more people will receive the information that they want then, and will not pursue the call through to the point where they are talking to a call handler. So, the abandonment should not be seen as more people waiting for a long time and getting fed up because they are waiting for a significant and inappropriate amount of time. I think that it is an area that we need to do a bit more work on.

[162] **Darren Millar:** You need to be able to measure that in some way.

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

[164] **Darren Millar:** Thank you very much for that. That brings us to the end of this particular part of the meeting, unless there are Members who want to ask a very brief question.

[165] **Jenny Rathbone:** We have not asked about workforce planning and the so-called looming crisis that the BMA mentioned. Is that just shroud waving or is it something that you

are planning for in terms of the appropriate staffing at the appropriate levels—both of GPs and nurses?

[166] **Darren Millar:** A brief response, please.

[167] **Mr Sissling:** This is a big question and anything could become a problem unless you plan for it. We clearly have information about the workforce, the age profile, anticipated retirement dates, pre-existing turnover in terms of leavers and our ability to recruit. That information guides us in terms of, for example, the number of commissions of GPs in the early stage of their career, and GP trainees. It has also allowed us to see one of the big issues, which is that there are some parts of Wales that are in a more challenging position than others. So, the process is in place, and we are not simply waiting for problems to develop—we are taking action. Some of that is to do with looking at opportunities, and working with professional bodies, to enhance and improve recruitment and retention, some of it is to ensure that we have the right input in training and educational programmes, and, in some cases, it means looking at the whole of the primary care workforce—doctors, GPs, nurses and others—in a way that means that we can look at that as an entirety rather than looking at it on a unique professional basis. So, I think that 'We are on top of it' is the answer to that.

[168] **Aled Roberts:** Could we have a note on the deanery figures?

[169] **Darren Millar:** The deanery figures for GP trainees.

[170] **Aled Roberts:** Yes.

[171] **Mr Sissling:** Yes, absolutely.

[172] **Darren Millar:** That would be helpful. Okay, we are going to have to draw this part of the meeting to a close. Thank you very much indeed for attending; you have stayed for an extended period, and we appreciate your attendance—it has been very useful indeed.

10:21

Papurau i'w Nodi
Papers to Note

[173] **Darren Millar:** We have two papers to note, namely the minutes of our meetings on 19 and 26 November. We also have a letter from Adam Cairns in relation to our health finances inquiry. I will take it that those papers 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

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

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

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

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:21.
The public part of the meeting ended at 10:21.