**AMRCW Council Meeting – Monday 13 June 2022 10:00 – 13:00**

# Microsoft Teams meeting

## Welcome and apologies:

Present:
Abrie Theron Chair (AT)
Olwen Williams VC (RCP) (OW)
Lowri Jackson (RCP) (LJ)
Simon Ford (RCoA) (SF)
Push Mangat HEIW (PM)
Phil White (BMA) (PW)
Llion Davies (FPH) (LD)
Diane Powles (RCN) (DP)
David Tuthill (RCPCH) (DT)
Gethin Jones (RCPCH) (GJ)
Steven Backhouse (RCS Edin) (SB)
Kellie Bateman (Trainee Rep)
Oliver John (RCPsych) (OJ)
Sara Moseley (GMC) (SM)
Jo Mower (Unscheduled Care) (JM)
Marged Wiliam (GMC) (MW)
John Bolton (Improvement Cymru) (JB)
Stacey Harris (WCLF) (SH)
Jaiker Vora (WCLF) (JV)
Suresh Pillai (RCEM) (SP)
Heather Payne (WAG) (HP)

Apologies:
Rowena Christmas VC
Chris Jones (HEIW)
Angela Mutlow (CHC)
Philip Kloer (FMLM)
Manel Tippett (GMC)
Alka Ahuja (RCPsych)
Chris Jones (DCMO)
Jack Parry-Jones (FICM)
Alex Gorton (FFLM)
David Bailey (BMA)
Jonathan Barry (RCS)
Clifford Jones (EOLC Lead)
Phillip Wardle (RCR)

## External Stakeholder Presentations (slides to be circulated):

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| 1. | Improvement Cymru | John Boulton |
| 2. | Leadership Fellowships | Kelly Bateman / Stacey Harris / Jaiker Vora |
| 3. | GMC - Good Medical Practice (GMP) | Marged Wiliam |

**External Stakeholder Updates:**

4. CMO Update - Frank Atherton

In terms of **COVID** things are quiet at the moment. The current wave of Omicron is receding, but continues to affect 1 in 75 at present, compared to 1 in 12 / 1 in 13. This is all positive, with far fewer people in hospital. There were 8/9 people in ITU beds before the weekend. The caveats around COVID is that we do expect future waves and we can't just assume it's all gone away.

Hopeful that the **vaccination** program will maintain the weakened link between community rates of infection and the harm that we saw in the 1st and 2nd waves. Did a lot of preparation work with Public Health Wales around surveillance and vaccination boosters in the autumn and linking that to the flu vaccination program. We can expect quite a difficult flu and RSV season.

**Monkey pox**, we have 4 cases in in Wales at the moment and around 400 across the whole of the UK, largely but not exclusively in men. It is not a sexually transmitted disease as such, but it seems to be transmitting in this way. There are discussions with JCVI about vaccinating as a preventive measure as opposed to vaccinating to protect close contacts.

The message we are trying to get out to the public and the profession is that it can present anywhere and anybody that presents with a fever and the strange vesicular rash needs to be isolated. Initially in England this was managed as a high consequence infectious disease and people were put into special isolation facilities, obviously with the numbers we have now realised this is not feasible.

**System pressures** - we are a system under pressure as is England. We are still seeing far too much harm in the community because of ambulances being backed up. We haven't really recovered fully from the Jubilee weekend when the pressures really did mount across the system. There has been a bit of easing, but not back to normal. There are system pressures that we are struggling to deal with in all the health boards.

Had a meeting with medical directors last week to talk about emergency care systems which are not functioning as well as they should across all health boards. Looking for some consistency about how they work and trying to underline the fact that we need to get timely senior clinician advice and assessment of patients in hospital and in A&E departments.

**Ukraine**: We're getting quite a significant number of arrivals from Ukraine into Wales - over 100 last Friday. This is putting pressure on the legal authority systems. We are a nation of sanctuary, but the reception centres that we set up are struggling to cope and are full at the moment. This is leading to local authorities having significant problems, housing people in hotels. Obviously, there are people who generously have come forward and put their names down to host Ukrainian families and local authorities are helping to make the links.

It's inevitably going to put pressure on the health system. We do have a national enhanced service for primary care, so people should be able to access primary care. But we are seeing numbers of people coming in with quite complex needs, not least mental health needs. There is going to be an additional pressure on various services. Maternity services will come under pressure at some point. Mental health is already probably seeing it.

The **TB** issue we talked about previously is pretty much under control in terms of managing the risk, but primary care is going to have a difficult time accommodating some of these services as well.

**AT**: How much is being done at the moment with regards to the back door? Every time somebody in the health board raises this they give a number of the patients that are sitting in beds that are ready to be discharged.

**FA**: There is a huge problem in social care. We all know this and we have been talking about this for a long time. There are efforts to try to improve this. Don't think there's going to be a quick fix, but irrespective of all of that, there are problems within the health system that we can solve - some of the delayed cases are waiting for physiotherapy or occupational health and these services can be provided through the health system. Some figures suggested of those delayed discharges about 50% were waiting for social care and 50% we're waiting for health interventions. Let's focus on the bit we can do as while waiting for social care to sort itself out.

There are people in hospital beds who should not be in hospital beds. They need to get out as quickly as possible. Social care is some of the answer, but there are things we can do with within our gift. That's all included within the six goals for emergency care. If we look at those and implement those fully across the system then we will start to make some progress. The fact that it is not easy in the system is recognised.

**JM**: With respect to whole system pressure, funding is approved for a piece of work that is looking at alternatives to ED admissions, throughput, post and upstream ED activity, of which domiciliary care is one. This will help because not only will it highlight the problems and issues that we all know, but perhaps it will also highlight solutions depending on local population needs.

The NHS benchmarking from last year for save intermediate care is available and the hope is once we get the workforce in place, we could look at their pathways and where improvements can be made. There is room for improvement - frailty being the obvious one, developing the frailty services, looking at what diagnostics you need to support the services as well as workforce.

Mental health - 111 press 2 is being rolled out this month, this is one of the alternatives to an ED admission. Patients can phone 111 and speak to a mental health practitioner and then they will link in with the directory of services and third sector groups rather than directing and signposting to secondary care or primary care.

The intermediate step down, unblocking the back door and then looking at the discharge pathways, the DU is doing a good piece of work looking at how can we expand and open up the discharge to recovering access pathways so patients are stopped staying in hospital becoming deconditioned, but getting them back out in the community. All links back to the prevention agenda, the Improvement Cymru agenda and the PA agenda.

**HP**: Welsh Government Anti-racist Wales action plan was launched a week ago and that has a number of actions for health.

5. HEIW Update - Push Mangat

HEIW now doing **ARCP**'s and will get information on how training has been affected by the pandemic. The feeling is that surgical training was affected more than others, but we will get more detail on this as the ARCP's complete. As mentioned already the workforce is tired and that includes trainees and it is important to recognise this as service pressures continue to be significant.

The move to a **single employer** has now been completed for all trainees in all the specialties. There have been some teething issues, particularly with anaesthetics. Shared services had outsourced some of their work and a number of issues occurred with the outsourcing. The issues were corrected within a week of being found out. HEIW is are still dealing with some individual issues and complaints. At corporate level HEIW is dealing with this as robustly as they can and have put it on the HEIW risk register.

The **Education Training Plan (ETP)**: The initial suggestion is that we will have an increase in the number of medical trainees and foundation trainees, but the breakdown is not available. The Foundation Trainee program expansion is part of a programme agreed with Welsh Government because of the unusual situation of not having enough foundation trainees feeding into our training programs. In addition, HEIW is in dialogue with Welsh Government about future medical school student numbers. Even if the North Wales Medical School mentioned before didn't happen, we would expand our number of medical students to match with what we need in foundation and later in core training. Accepting that we have a porous border, we should in future have enough of our own foundation trainees applying for posts in Wales.

**Stakeholder Reference Group**: This is a new process and the first attempt at trying to engage further with all of HEIW stakeholders. Although it may not have satisfied most people we are on the path of trying to do that. AT attended in April and OW in June. HEIW is committed to setting up a specific MOU with every college in order to have a good transfer of information and good sharing of training issues and the hope is that all the colleges will join in this.

**SB**: The general thinking is it for a service or an organisation or any system to run efficiently it needs a bit, 10% wiggle room or headroom so you would have 90% capacity. To that end as a medical student there were more Foundation or Junior House officer roles than there were medical students and everyone got a job. It was reported last year that there were medical students who couldn't get a foundation post because there were more medical students than there were foundation trainees. Are you not going to be contributing to this problem with the graduates?

**PM**: This is an oversubscription of foundation. The problem was partly because medicine is on the shortage occupation list which allows trainees from abroad to apply. HEIW is obliged to find everybody who applies a foundation post. Our share of this in the UK was in the region of 40 or 45 posts. It happens every year and HEIW normally manage it. If we need extra posts, we go ahead and get them. The degree of oversubscription always fails. This is because of attrition or people changing their mind from overseas or failing exams, or deciding to have a break or other reasons.

**KB**: Single lead employer is a post code lottery particularly regarding who pays for locums and it is also affecting maternity pay. There are a lot of trainees quite angry about this and the disparity particularly with occupational health. If they have a needle stick injury or have any occupational health needs the hospital that they work at does not know they exist and have no occupational health records for them. Trainees are being told to go to Velindre for all their risk assessments and any injections or follow up. If you're in North Wales, West Wales, Newport, this is impractical.

**PM**: Not aware of the local issues. Depends how the locums are organized and HEIW have discussed this in particular with shared services to make it easier. All health boards have in the past used different systems for doing all of these things and all things described existed before, so whilst it's an issue, it's not an issue with single lead employer, it's an issue that happened anyway.

As for occupational health, one of the things that became very apparent is that the waiting list for occupational health review in the health boards was so long that you wouldn't have had any occupational health advice at all if not gone to Velindre. It is an issue about occupational health across the whole nation and it is just as bad for everybody, not just trainees. If there are some specific issues, I understand that occupational health (in Velindre) have to give the advice, but if you have to have blood tests and things like that, it needs to be done locally like with needle stick injuries. Will feed these back or inform Ian Collings and he will let Tom Lawson know in order to keep monitoring the situation.

In retrospect it is not perfect, it never was going to be, but there are a lot of people giving good feedback about how it's worked for them. In the past you had to register every time you went to a different health board and go through all the same checks and you couldn't take your e-mail address with you. There was a huge number of things that were negative in the old system reported on social media and elsewhere, asking why we didn't have a single lead employer, especially those who'd experiencing single lead employer arrangements elsewhere. HEIW therefore was committed to doing it.

HEIW takes all the feedback seriously and are doing their best to support shared services to deliver the employee model.

6. GMC Update - Sara Mosely

**Professor Dame Carry McEwan** was appointed as chair of the GMC last month. Known to us from her time chairing the AoMRC until 2020. Going to be setting up meetings with her to keep in touch on a regular basis.

**UKAS** meeting was on Thursday where the focus was on workforce. It was a good meeting in that there was an open flow of conversation. There was a helpful update from PM and his colleagues on the workforce strategy. The GMC shared data, which they are really keen to have used as much as possible in terms of planning and supporting the medical profession. This data can be made available to members. It was a sobering discussion, but one that could help us plan and think about what we want to do regarding workforce, including PA's and AA's.

Regarding correspondence from DT, the GMC have undertaken to come back with Ian Collings to tell us what is going on at a national level regarding the approach to induction and training for **overseas trained doctors**. Ian Collings is leading on this for HEIW and working with the GMC to ensure there is a joined-up approach.

Action: AT to contact Ian Collings and invite to next meeting

The GMC have also been working with the Welsh Government on the introduction of **Welsh language standards** for healthcare regulators, with an understanding that it will be laid in the Senate on Thursday. Obviously, all of you have been subject to those standards for some time, but the GMC have not yet and in terms of regulatory reform, they are working quite intensively with the Department of Health and Social care on this.

The GMC worked with the Royal College of Anaesthetists and the Faculty of PA to revise both the **PA and AA curriculum**. Interim professional standards have been published. They were included in the review of good medical practice. The GMC is shortly going to be engaging on revalidation arrangements and processes for PA's and AA's. Also supporting the extension of prescribing responsibilities to PA/AA's after regulation and working with the Department of Health on this. The GMC is linked into the All Wales MAP oversight group and are working closely with HEIW.

Finally, the **National Training Survey** closed in May, hoping that the findings from that survey will be available next month. Again, will be working closely with HEIW on this.

## Internal Meeting

7. Minutes from previous meeting - Two corrections:

i. Page 2 number 4 - the second point, the "12 points" should be "A dozen things that the NHS could do tomorrow to help with the medical workforce crisis".

ii. Page 5 point 8a should be PRSB

David Tuthill confirmed the minute is a true reflection of our last meeting with the 2 corrections.

8. Chair report - Abrie Theron

AoMRC website: Helen Stokes-Lampard informed AT that Max Prangnell agreed to the use of the web page. AT not yet certain what we are able to publish, but AT has stated at the minimum we would like our agendas and minutes as well as contact details of the chair and VC's. Ideally, we should have all the college and faculty representatives as well. AT will follow this up further at council in July.

Nobody has got back to AT regarding the AMRCW procuring admin services from member's staff. At the moment AT is managing everything and is coping. If it becomes too onerous AT will explore how we advertise for support on an ad hoc basis.

**Meetings attended since our last meeting:**

JPJ agreed to represent the AMRCW at the COVID-19 enquiry.

RC attended the Revalidation oversight meeting 10 March 2022.

RC attended AoMRC council on 6 April as AT was on A/L in SA. A summary of the meeting was circulated.

AT attended the HEIW stakeholders meeting 25/4/22 following that an additional briefing session on the ETP was decided upon and the invitation was sent to you all.

Olwen attended the HEIW Stakeholders Reference Group on 6/6/22.

AT attended the PRSB Stakeholders on 28 April, where the AMRCW was officially welcomed.

There were several GMC meetings attended by AT:

GMP with AoMRC 27/4/22

Conference 4/5/22

GMP in Wales 11/5/22

1:1 with Sara Mosely 16/5/22

UKAF 9/6/22

Unfortunately, I was unable to attend the NTG meetings and all have recently been cancelled.

9. Updates

a. COVID Enquiry - Jack Parry-Jones (emailed)

*Baroness Hallett, Chair of the UK Covid-19 Inquiry, has asked me to let you know that she has today sent her recommended changes to the Terms of Reference to the Prime Minister. This is an important milestone and is only possible thanks to the helpful and detailed responses received from people across the UK during the*

*consultation. You can see Baroness Hallett's recommendations on our website, at www.covid19.public-inquiry.uk.*

*As you know, the Inquiry conducted a four-week consultation exercise. During this period we travelled across the UK to meet over 150 people who were bereaved due to the Covid-19 pandemic. We also met with representatives from 145 organisations from a range of sectors including health, social care, education, and business. We received over 20,000 consultation responses by post, online and via email. The recommended changes to the Terms of Reference follow the Inquiry's thorough analysis into these responses.*

*Baroness Hallett has recommended that the Terms of Reference be expanded to include children and young people, the mental health and wellbeing of the UK population (including those bereaved by the pandemic) and collaboration between regional, devolved and national government, and the voluntary and community sector. She also recommends that the Terms of Reference be reframed to put possible inequalities at the forefront so that investigation into the unequal impacts of the pandemic runs through the whole Inquiry. This important recommendation will ensure the Inquiry is inclusive in its approach. Finally, there are changes relating to a number of key areas that we heard about during the consultation, including care in the home, enforcement of the rules, support for victims of domestic abuse, and first contact with the NHS, including 111 and 999 services.*

*Baroness Hallett believes the changes she has recommended properly reflect the feelings and experiences shared through the consultation. She hopes that the Prime Minister will accept her changes, recognising the input of everybody who participated. Once our Terms of Reference have been finalised by the Prime Minister, the Inquiry will formally be established with full powers under the Inquiries Act 2005. We will continue to work completely independently of government.*

*We are committed to running a wide-reaching listening exercise that will hear the experiences of people who have suffered during the pandemic. This will include not just bereaved families, but also other groups that have suffered, such as long Covid survivors, students, business owners, and people who have missed out on treatment for non-Covid conditions. We will hear from people across the whole of the UK, and will make the listening exercise accessible to all parts of society with a particular focus on disadvantaged groups. If you would no longer like to receive our updates, please reply to this email to let us know.*

b. Healthy Weight Healthy Wales Update - David Tuthill

Implementation group had its first meetings with agenda setting and pulling the evidence together. It is likely to be a difficult task producing change, but feedback from a couple of people reiterated the importance of this work. Things will start rolling forward in the coming months. The government setting the standards and the implementation will happen from the community into healthcare.

Decided to keep on the agenda for a brief update if needed.

**KB**: Are you engaging with any of the planned care or surgical boards? We have been talking about obesity in general surgery and having a weight limit on benign conditions like lap chole's and hernias, if your BMI is over 35 not offering an operation until you lose weight, which obviously has some big equity issues.

**DT**: This is a Welsh government group on which he is representing the Academy of Medical Royal Colleges from a paediatric background. Happy to take this to the group in the next meeting. There were a wide range of people but not sure if surgery was represented. Can go back and look at the membership. This was not an issue that came up.

**HP**: Don't think it will be on the agenda because it has got massive equity issues and it would be a very difficult policy to have. You will have to demonstrate the difference in medical benefit. Operative prehab is the answer to a lot of these things. Prohibiting people from having services due to their actual weight if it isn't an actual risk would not be a policy that the Welsh Government would be likely to support.

**AT**: This has been discussed about five years ago and at that point we have had fairly similar views in that this cannot become a policy because Welsh Government cannot get behind it. You can however address this with shared decision making and prehabilitation, discussing risk vs benefit to operate and address risk by working with the patient to get them as optimal as possible for the procedure.

**OW**: Some people have high weight are not obese, they happen to be bodybuilders with huge muscle mass.

c. Advanced & Future Care Planning - Clifford Jones (via email)

⇒ DNACPR – 2 yearly review of policy due this year, but decision made that no changes required at present. Emphasis that carrying out the regular audit is strongly encouraged.
⇒ Non-medical completion of DNACPR – Following changes at last review of dnacpr policy, a competency framework is being developed.
⇒ AFCP – Electronic AFCP system. Outline Business Case due to be submitted to WG. Hopefully there will be a go ahead for full business case.
⇒ Cross Party Group inquiry into experiences of EOLC in community and care homes during pandemic – RCGP Wales is submitting response/evidence

d. Consultant Recruitment - Olwen Williams

Documented was signed off and circulated by Welsh Government. Pleased we managed to get through this within a year of actually raising the issues. Guidance is much simplified. Please make sure that your HR departments and your medical directors are aware. Would be good to keep a watching brief on what is happening. If you have some issues and please let Olwen know and she will feedback to Welsh Government if people are not complying to these regulations. RCP certainly noticed a change and are seeing more job descriptions coming through from certain health boards. College presence on interview panels is part of the new guidance.

Action: All to feed issues with compliance back to OW

10. AOB

a. PA & AA in Wales

AT had feedback from the group about concerns and concerns were also raised in the GMP meeting. KB initially raised the issue with regards to us training physicians associates and then we are not able to employ them one or two years post training, which is a significant loss of resource once invested into training. HEIW set up a task and finish group looking into AA's and Cardiff is on the verge of starting to train and employ 2-3. There are already a substantial amount of AA working in Hywel Dda and that seems to be working well. Swansea Bay is also in the process of looking to start training AA's. Put on the agenda to discuss it as a group to see what the feeling is around PA/AA as there was quite a lot of negative sentiment expressed in the GMP Welsh meeting

about the distinction that needs to be made between a doctor and PA/AA. Patients absolutely need to be fully informed, but Is there anything we can do to move it forward or not?

**SM**: There are a lot more conversations that we need to have about PA/AA and it would be good to hear from people. PA's have already been imbedded in the workforce and where it is working they are part of a multidisciplinary team. They are not doctors, that is not the intention and there does need to be clarity, as the roles develop and they come into regulation there should be a discussion about how we optimise the pressures on the workforce. Having people work at the top of their grade seems to hold a huge amount of promise and it enables more flexibility. We haven't actually had that response to any of the other GMP consultation sessions. This specific reaction at that particular meeting was interesting. There is some material / blog going on to the GMC of someone who has been working with PA's for a long time with some answers to questions. The GMC has had a lot of questions about the role of PA's and areas of practice so an area was created to address those issues. Whatever comes out of our discussions here in Wales, we can feed into that as well.

**PM**: With regards to opportunities, the HB's asked HEIW to train a certain number of professionals including PA's and then the HB's did not have jobs for them. This has been addressed this year with more jobs available than PA's qualifying here in Wales. This may be a turning point. PA's that are employed to work to the medical model doesn't mean other professions can't. These professionals are to work in the medical model, but they are separate from other professional groups. The issues have been addressed prior to implementing the courses and prior to implementing the programmes. There were task and finish groups for both PA's and AA's to see if they would be required within our NHS services in Wales. On both the occasions there was a positive recommendation for HEIW to train them, so it has been done with the full agreement of HB's. HEIW was planning to start with AA's prior to COVID and wants to restart that process now. There are two anaesthetic associate providers, one in Birmingham, one in UCL. One provides a postgrad diploma, whereas the one in UCL provides a masters. We are starting with Cardiff and we hope with Swansea, Betsi Cadwaladr is also very interested. We have to consider it in terms of the service need of the planned care programme, which is going to take many years to be sorted. It's not a question of what we want, it's what our patients need and we have to work alongside these professionals to deliver what our patients need. There's a real piece of work to be done here. Anaesthetic associates really do need the regulation more than PA's, because there needs to be prescribing, drawing up drugs and giving them, which is not necessarily as important for PA's, although there are a lot more PA's. The Chinese whispers about what they can't do makes people forget what they can do, and we've had repeated examples where a PA's have actually assisted deanery training, where they've allowed deanery trainees to access their clinics or their theatre lists because there's somebody doing the ongoing work within the ward and providing continuity of care. We need to sort this out step by step and make sure that we do it safely and work with the GMC to make sure that is the case. There is a lot of mileage in it and HEIW is supportive as our patients need them and therefore it's the right way to go.

**KB**: Experience of PA's has often been very good, but a lot of the ones spoken to in Wales are getting 2 year posts after graduating in which they rotate every six months, but then they're not getting long term jobs after that. Should we review each of the college's guidelines of how to work within the wider workforce and then use that to signpost health boards to develop long term job plans for the physician associates so that they have a clear role that is well defined early on? When interviewing physician associates recently, very few seem to know what their jobs are going to look like in five years. This will enable them to see where they will be in 5-10 years. This is something that needs to be clearly defined from the outset.

**OW**: Should we have a representative from the faculty of Physician Associates on this group as they are aligned to physicians. We do have a Wales Rep and we can invite them to the next meeting. At the moment they are in a very difficult space pending hearing about their regulation. A recent article in the news around a GP practice

where they employed PA's the headline was "*not proper doctors"*. It would be nice to hear their voice rather than discuss them and to have a more open and transparent productive conversation.

Action: AT to get contact details and to invite to next meeting

**AT**: It is difficult for the colleges as they won't employ PA/AA's directly. We have to think how the Academy can influence employers to create posts rather than just telling them about the benefits. We also need to establish how we can support this group in the interim.

**HP**: Interprofessional working is absolutely vital for the future. There's plenty of work for everybody. Let's hear from the ones where it is working well, but we also need to solve the problems where it's not working well i.e. anxieties from doctors around accountability. Interprofessional working and understanding the different cultures and backgrounds that we come from, skill sets and also being good at delegating and accounting for work. Being able to work in this space is probably a skill set that needs to be developed by doctors to work well with PA's and AA's. Once they can work well together, they will actually want PA/AA and generate the demand. There's probably a little bit of loading on both sides.

**AT**: Academy can potentially help with this and push that agenda forward. We will get speakers to come and talk to us at the next meeting as a starting point to taking this forward.

b. Chair position

AT's First year will come to an end at the end of this year. I would be happy to continue if you are all happy. One point I need to raise is at that at the moment I'm giving all the possible time I have available and a lot of the issues we are addressing are reactive. If you want the Academy in Wales to be more proactive, and any of you feel they have head space to do that, AT would be happy to stand aside for this person to come in and do that. You can think about that and we can pick that up at the meeting in September.

c. DP

This will be DP last meeting as she is stepping down from her post at the end of next month. There will be a new associate director. AT thanked DP and stressed the importance of all in healthcare working together for the benefit of pts. Asked DP to inform us who is taking over from her in order to include them.

11. Confirm date of next meeting: AM Thursday 22 September (f2f or hybrid)