Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

The National Assembly for Wales
The Health and Social Services Committee

Dydd Mercher, 15 Tachwedd 2006
Wednesday, 15 November 2006

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau Cynulliad yn bresennol: Rhodri Glyn Thomas (Cadeirydd), Brian Gibbons (y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol), John Griffiths, Helen Mary Jones, Jonathan Morgan, Lynne Neagle, Jenny Randerson, Karen Sinclair.

Swyddogion yn bresennol: Steve Elliot, Pennaeth Cyllid, Cyllid Gofal Ysbyty a Rheolaeth Gyllidebol; Sian Evans, Rheolwr Prosiect Presgripsiynu Annibynnol; Dr Tony Jewell, Prif Swyddog Meddygol; Peter Jones, Cwnsler Gwasanaeth Seneddol y Cynulliad; Rosemary Kennedy, Prif Swyddog Nyrsio; Ann Lloyd, Pennaeth, Adran Iechyd a Gofal Cymdeithasol; Alastair Meredith, Fferylliaeth a Phresgripsiynu; Karen Morgan, Fferylliaeth a Phresgripsiynu; Kathryn Potter, Gwasanaeth Ymchwil yr Aelodau.

Eraill yn bresennol: Muriel Barber, Rheolwr Gofal, Hosbis i Blant Claire House; Viv Cooper, Cyfarwyddwr Clinigol, Gofal Hosbis George Thomas; Gill Devereaux, Swyddog Proffesiynol, Cymdeithas Ymarferwyr Cymunedol ac Ymwelwyr Iechyd Cymru; Tina Donnelly, Cyfarwyddwr, Coleg Brenhinol y Nyrsys Cymru; Dr Andrew Fowell, Cadeirydd, Grŵp Cyfeirio Arbenigol; Helen Rogers, Ysgrifennydd Bwrdd Cymru Coleg Brenhinol y Bydwragedd; Karen Wright, Prif Weithredwr, Hosbis i Blant Claire House.

Gwasanaeth Pwyllgor: Jane Westlake, Clerc; Catherine Lewis, Dirprwy Glerc.

Assembly Members in attendance: Rhodri Glyn Thomas (Chair), Brian Gibbons (the Minister for Health and Social Services), John Griffiths, Helen Mary Jones, Jonathan Morgan, Lynne Neagle, Jenny Randerson, Karen Sinclair.

Officials in attendance: Steve Elliot, Head of Finance, Hospital Care Finance and Budgetary Control; Sian Evans, Project Manager, Independent Prescribing; Dr Tony Jewell, Chief Medical Officer; Peter Jones, Counsel to the Assembly Parliamentary Service; Rosemary Kennedy, Chief Nursing Officer; Ann Lloyd, Head, Health and Social Care Department; Alastair Meredith, Pharmacy and Prescribing; Karen Morgan, Pharmacy and Prescribing; Kathryn Potter, Members' Research Service.

Others in attendance: Muriel Barber, Care Manager, Claire House Children's Hospice; Viv Cooper, Clinical Director, George Thomas Hospice Care; Gill Devereaux, Professional Officer, Community Practitioners' and Health Visitors' Association Wales; Tina Donnelly, Director, Royal College of Nursing Wales; Dr Andrew Fowell, Chair, Expert Reference Group; Helen Rogers, Secretary to the Royal College of Midwives UK Board for Wales; Karen Wright, Chief Executive, Claire House Children's Hospice.

Committee Service: Jane Westlake, Clerk; Catherine Lewis, Deputy Clerk.

Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

[1] **Rhodri Glyn Thomas:** Bore da, a chroeso i'r cyfarfod hwn o'r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol. Atgoffaf aelodau'r pwyllgor a'r bobl sy'n cynnig tystiolaeth y dylent aros nes bod y golau coch yn ymddangos ar y microffon cyn dechrau siarad neu bydd rhai o'u sylwadau yn cael eu

Rhodri Glyn Thomas: Good morning, and welcome to this meeting of the Health and Social Services Committee. I remind committee members and those giving evidence that they should wait until the red light appers on their microphones before they begin to speak or some of their

colli o'r Cofnod. Croesawaf bawb sydd yn yr oriel, hefyd. Fe'ch atgoffaf fod angen diffodd unrhyw offer electronig, gan gynnwys BlackBerrys. Nid yw'n ddigonol eu gadael ar 'dawel'; rhaid iddynt gael eu troi i ffwrdd. Os fydd angen i ni adael yr ystafell, dilynwch gyfarwyddiadau'r tywysyddion, os gwelwch yn dda.

comments will be lost from the Record. I also welcome all those in the gallery. I remind you that all electronic equipment must be switched off, including BlackBerrys. They must not be left on 'silent'; they must be switched off. If it becomes necessary for us to vacate the room, please follow the instructions given by the ushers.

[2] Nid wyf wedi derbyn unrhyw ymddiheuriadau. Os nad oes unrhyw ddatganiadau o ddiddordeb, symudwn ymlaen at yr eitem nesaf.

I have not received any apologies. Unless anyone has any declarations of interest, we will move on to the next item.

9.31 a.m.

Adroddiad gan y Prif Swyddog Nyrsio
Report of the Chief Nursing Officer

[3] **Rhodri Glyn Thomas:** Croesawaf Rosemary Kennedy, Gill Devereaux, Helen Rogers a Tina Donnelly. Yr ydym i gyd wedi derbyn copi o'r adroddiad ysgrifenedig. Rosemary, a oes gennych unrhyw beth i'w ychwanegu at yr adroddiad ysgrifenedig?

Rhodri Glyn Thomas: I welcome Rosemary Kennedy, Gill Devereaux, Helen Rogers and Tina Donnelly. We have all received a copy of the written report. Rosemary, do you have anything that you wish to add to the written report?

[4] **Ms Kennedy:** Yes, Chairman.

[5] Diolch yn fawr a bore da.

Thank you very much and good morning.

[6] Thank you for the opportunity to come to talk to you about nursing issues. Chairman, you have already introduced my colleagues and the only one who may be less familiar to you is Gill Devereaux, the new Welsh representative for the Community Practitioners' and Health Visitors' Association arm of Amicus. I think that it is her first time here. You know Helen Rogers from the Royal College of Midwives and you most certainly know Tina Donnelly very well indeed.

[7] In July last year, you asked us to come forward with a report on nursing issues. This report is titled the 'Report of the Chief Nursing Officer for Wales' and, if I may, Chairman, I would just like to make one clear distinction: as the chief nursing officer in the Welsh Assembly Government my key responsibility, and that of my nursing officers, is to provide professional advice to the Minister, to you as Assembly Members and to colleagues in the policy divisions, working closely with the chief medical officer and, of course, Ann Lloyd. The report will not deal with what is my bread-and-butter employment. However, it is trying to deal with the fact that, with my other colleagues who are heads of professions, I am the head of the profession for nursing and midwifery and the whole arm of our profession in Wales. That is why the report has been put together in concert with our major unions and major organisations, including the Royal College of Nursing, the Royal College of Midwives and the Community Practitioners' and Health Visitors' Association.

[8] Nursing is an enormously broad and complex profession. If we were to try to include something about every element of nursing, where it operates, you would have had something like *War and Peace* on your hands. Therefore, what we have tried to do is search back through Assembly records to note the key areas of concern, or those that have caused you

concern in the past, to select two areas for this initial report. If this is acceptable, we will offer similar reports, with additional examples, in the future.

[9] The areas that we have selected are workforce—there have been major discussions about that—and quality of care. I would like to draw your attention to the fact that, although we are concerned to emphasise that real issues about staff shortages, pressures, the acuity of patients, and things such as violence, abuse and misuse of our staff, are important and key, I do not want us to continually linger on the very negative elements. We have around 45,000 nurses working part-time and whole-time in Wales and the majority of them are doing a fantastic job. They are quietly professional and contributing to high-quality patient care. They are receiving a lot of recognition nationally, in terms of awards, as well as daily from the patients and the relatives for whom they care. Therefore, we want to ensure that we recognise that everyday work.

[10] The first chapter is on the workforce. I guess that the first questions that almost anyone in the street would ask are, 'How many nurses do we need, how do we know how many we need, where will we get them from, and what are they going to do?'. Therefore, there is an element here that I am sure you will want to pick up on in terms of establishments; I know that the professional organisations have their own issues around establishments, which they may wish to comment on today, but they would probably prefer to make a comment to you more directly.

[11] On the appropriate deployment of skills and competencies, 'competencies' is a word that appears in our vocabulary almost daily. It is challenging the whole issue of professionals doing what professionals always did, as opposed to professionals acquiring the competencies required for the healthcare delivery that we expect in modernised NHS facilities.

[12] The last point on general nursing issues is about career pathways and job satisfaction, and its impact on retaining staff. Recruiting, training and retaining has been covered here, together with what I have described as the 'bounce' that we have; this will come before you a little later on in this financial year, when we start to think about commissioning. It is how we smooth out the bounce of recruiting too many into training and then not having jobs for them, versus recruiting too little and then having to go abroad to fill those gaps, or having to find other ways of doing it. Some of that has resulted in huge agency expenditure in the past.

[13] Training and employing for the new NHS, with its focus clearly on primary care, means that we will have to radically rethink how we have historically always allowed secondary care to drive the workforce plans. We are looking at having to change that—certainly with this new workforce planning round that we are about to enter into in December.

[14] On retention issues, it is about flexibility and family-friendly hours. You will see that, in the first statement, I have noted that the majority of nurses are women, with responsibilities for families, and perhaps for caring for other members of their family. Family-flexible hours are extremely important for us in retaining and valuing our staff.

[15] Finally, on international recruitment, I know that researchers have drawn your attention to the fact that a UK decision was made earlier in the summer that, because of the position in which England, largely, and other parts of the devolved administrations, found themselves in terms of employing newly qualified staff, they would remove the less-experienced nurses from the hard-to-recruit list, and, therefore, reduction in international recruitment was indicated at that stage. We must keep international recruitment on our radar. We have already had it made explicit that the United States is about to do an enormous recruiting campaign in the UK. The US considers that it can absorb every student nurse who is trained in the UK. Therefore, if we do not value and employ our nurses, they will find it exceptionally attractive to go to some of the US markets.

[16] The second chapter is about quality of care, and patients and their families are central to everything that we do. It is about their range of expectations and experiences in the NHS, which are determined by the care—and we have mentioned 'Fundamentals of Care' here in particular—and monitoring and measuring. However, we have been upfront—there are some significant failures, even with a document as explicit as 'Fundamentals of Care'. We still, somehow, do not seem to be getting it right in terms of good, sound patient nutrition, and also in terms of the environment of care, such as hospital cleanliness, and so on, which I know has concerned committee members in the past. Therefore, the role of leadership and strong ward management skills are vital. With that, I do not want to take up any more of your time. I am sure that you want to ask us questions about the things that we put into our document. Diolch yn fawr.

9.40 a.m.

[17] **Helen Mary Jones:** Thank you for the report, which I found very useful, and for your additional comments today. In the summary statement, you say that it is not helpful to spotlight negative aspects, but you will understand that it is our job as a committee to highlight concerns. I think that it is legitimate for you to say that we ought to do more patting on the back than we do, but areas of concern will be highlighted. So, forgive me if I focus on those, although we all know that the number of good-news stories and the number of patients who are delighted with the front-line care that they receive hugely outweigh the problems. One challenge for us is how we can work with the profession and with the Minister to try to ensure that nurses are enabled to do what they do best and that things do not get in the way, such as old-fashioned working practices that you cannot balance with your family life and so on.

[18] I will ask you about a few issues. In the document, you refer a few times to the fact that it is quite a tough environment at the moment. Do you have anything further to say about the issues with regard to reconfiguring hospital services and the plans, therefore, to provide more services in the community? What would you say is the impact of some of the uncertainty around what will happen with secondary care? What impact is that having on the profession? Is that having an impact on recruitment and, in particular, retention in some areas? If you are not sure whether your hospital will be there next year, are you likely to move away to work in England, because at least you know that that will still be there? Is that having an impact on morale? If so, are there things that we can do to help with that?

[19] With the emphasis on the need to provide more nurses in the community rather than in hospital settings, can you say more about what needs to be done to make that possible, because it obviously is not possible to take a nurse who is used to working in a ward setting and send her out into the community by herself? So, what needs to be done to make that possible? Is there anything further that we need to do? Many of us are concerned about the apparent rise in the use of agency nurses again. Is there anything further that needs to be done to deal with that? As you have highlighted in your comments and in the report, this is a real issue for many of us and seems like an awful waste—sometimes it is the same nurses who are not working in a full-time setting, but who are working for an agency. So, what do the trusts and the health boards need to do to address that?

[20] I have some questions on clinical care, but perhaps we should deal with recruitment and retention first.

[21] **Rhodri Glyn Thomas:** We will deal with recruitment and retention first.

[22] **Ms Kennedy:** Thank you; I might otherwise have forgotten what you said.

[23] Thank you for your comments. On your question about uncertainty and the impact that it has on staff in terms of, 'Will I have a job tomorrow?'—because everyone has mortgages and commitments—the delay that we had in deciding what we were going to do about neo-natal intensive care, which was quite a long time coming to fruition, given the changes in structure within Wales, led to underinvestment when there was no clear pathway set out with decisions, such as whether we should be investing in new equipment and so on, if this was going to change. People were then beginning to think that no decision was being made and that maybe they should take the opportunity to move elsewhere. So, I know that those sorts of things have been well tracked and it was always clear within the Welsh Assembly Government and Mrs Lloyd's department that we needed to get on and stabilise the situation so that staff had a future.

[24] My feeling is that, obviously, consultation around the restructuring of the acute secondary services in Wales has, of course, caused some concern. However, I think that, on the whole, most of the professionals that I meet—and, certainly, what I would call the nurse leaders and therefore, the people who have the responsibility for ensuring that their staff are well informed, can see some of the benefits of this. I was in Pembrokeshire and Carmarthenshire and some of the nurse leaders there would say, 'In terms of the proposals, we have been through this, we have taken it out, and we understand what is around'. I think that that is the sort of general feeling that I am getting on that, but I would say that people obviously cannot live with delay and uncertainty for an awfully long period of time. I think that we are seeing this uncertainty coming through in terms of financial balance within the trusts. We have just asked all our acute trusts to tell us the position regarding employing newly qualified staff from the September 2006 outturn. A significant number of them are being employed on temporary contracts rather than open-ended contracts, because the hospitals have to be realistic. Management boards have to be realistic about what they will be providing and where they will be providing it. It does not mean that they are not being taken on as full-time staff and that they are not being enabled to establish themselves in their profession, but significant numbers are being employed on temporary contracts.

[25] In terms of redeploying staff, it would be wonderful if a nurse was a nurse was a nurse, but that is not the case. Although it might seem like a reasonable financial solution to pick people up and move them up and down like chess counters, you cannot do that. There is an issue about competency and patient safety, and the trusts are well aware of this. In fact, part of the work that the National Leadership and Innovation Agency for Healthcare has been doing is about ensuring that, when there are service changes, there is education, training and development to fit those moves. In my view, there are some issues around more blurring of the boundaries. For instance, in intensive care, we have, in certain hospitals, adult intensive care, children intensive care, neuro intensive care and so forth. A core amount of those skills is fairly similar. Therefore, this is a question for us, as a profession, to take back to our education partners and ask, 'How can we build something around post-registration specialisation that picks up the core and then allows us to develop the add-ons that are specific to adult, children or neuro intensive care and so on?'. We have not done that in the past, therefore, to be very truthful, we are not in the position to move as swiftly as we should, but it has given us a flag.

[26] I do not know whether anyone else from the organisations wants to add anything, or whether we are out of time on that question. Have I answered all of your questions, Helen Mary?

[27] **Helen Mary Jones:** Can I ask a very brief supplementary question, Chair? It arises from your answer. You referred to 'Agenda for Change' and financial balance. One of the issues on which I think that we, as a committee, are getting conflicting messages is around the implementation of 'Agenda for Change', the extent to which that is rolling out, and the impact that it is having on some of the workforce issues that you are talking about, on people being

taken on, and on financial pressures leading to posts not being filled. Very luckily, we have not seen the redundancies that they have sadly seen in England. However, from talking on the ground to front-line staff, I certainly get the impression in west Wales that there are issues about posts not being made redundant but being left empty for quite a long time. I wonder whether that was something that you picked up.

[28] Also, do you have any comments on the roll-out of 'Agenda for Change' and the implications that that has? It is important in terms of retention, valuing staff and rewarding them properly; therefore, do you have any comments about the progress towards that and how we are getting there? What impact, if any, is the need to implement 'Agenda for Change' having on that financial balance in the environment whereby, perhaps, people are being taken on temporarily, as you said, for what are, in all intents and purposes, full-time posts, but because of financial insecurities, trusts cannot make those commitments?

[29] **Ms Kennedy:** 'Agenda for Change' is the most far-reaching single-pay structure change that we have seen since the inception of the NHS. It exists across the UK. Within Wales, it is being managed through the lead within Mrs Lloyd's department and through the partnership forum, which the Minister attends. All my colleagues here from the organisations are fully involved in that, and they are—as you might imagine—maintaining the pressure to ensure that staff are assimilated onto the right structure as soon as possible. That work is unfinished, so I am unable to comment any further on that.

9.50 a.m.

[30] I think that 'Agenda for Change' was welcomed by everyone, particularly as it links knowledge and skills frameworks. So, we are rewarding people for what they do and for the knowledge and skills that they have and put into practice. You know that 'Agenda for Change' does not apply to people who are not employed in the NHS, and you have heard evidence previously about the pressures that some of the professional organisations have been applying, and the successes that they have had in persuading independent employers of nurses to look at that as a key main structure for pay.

[31] In terms of the financial insecurity, I do not want to link in your mind—and it is a mistake on my part if I have done so—the financial insecurity around the shape of the services and where they will be with the 'Agenda for Change' issue. That is an entirely different issue, and the funding is well discussed on that. However, what I said about the temporary employment is about whether, if we are going to be moving people into the community, we will still need the same type of in-service secondary care. That is the type of insecurity that I meant, in terms of whether the money will then have to move from secondary care into primary care.

[32] **Rhodri Glyn Thomas:** Helen, did you have another question?

[33] **Helen Mary Jones:** I have some questions on the clinical side of it, but perhaps other people have questions about recruitment and retention.

[34] **Jenny Randerson:** You say on page 7 that a wide interpretation has been applied to the word 'vacancy', which is something that confuses us all, I think. Where does the counting of agency nurses fit in with the definition of a vacancy? You said that a lot of posts are being filled on a temporary basis, but what I hear anecdotally is that agency nurses are often brought in, in very much the same scenario, because the trusts want to avoid making a long-term commitment. They use agency nurses when they are pushed to do so and when the pressures get too great, and then they leave the post vacant for the rest of the time. Do you try to factor those two things together? The creation of the all-Wales agency is very important in that regard.

[35] Along similar lines, there is a huge variation between trusts, in percentage terms, in the number of vacancies that they have. There is also a variation in terms of the number of agency nurses employed by trusts. What are you doing to try to encourage the spread of good practice beyond the creation of the all-Wales agency?

[36] I have a separate question on the issue of commissioning training places. I am informed that the commitment in terms of the money comes through rather later to the training organisations, if I can put it that way, in Wales than it does in England. Therefore, they are able to commit to a certain number of places for training nurses rather later than they are able to in England. Does that have an impact on the way in which we recruit nurses, or potential nurses, for training?

[37] **Ms Kennedy:** If I am absolutely honest, I do not believe that there will ever be a time, even in the medium term, when we can work completely without agency staff. I want to value agency staff, because a lot of them chose to do agency work because it fits in with family commitments, and because they like the challenge of working in different environments. On the whole, they do a fantastic job. Over time, we have come to rely on agency staff to fill the hard-to-recruit-to vacancies in particular—I am talking about the very specialist areas.

[38] If we talked about this without thinking about anything more than the straight logic of using agency nurses, what would the options be? The options would be for trusts to try to find an indicative establishment for all eventualities, which would have a high and almost unaffordable cost. There are some instances—we have examples of this in Wales—of staff being underutilised, because the skill mix and the numbers are for the worst-case scenario and not the average.

[39] If we then say, ‘Okay, establishments are set for what we can consider to be an average, looking retrospectively and building in all sorts of things about the complexity of needs, the acuity, which is how seriously ill the patients are, and turnover and so on’. So, we would build up a core establishment, and if there are demands that cannot always be predicted, they will have to be managed somehow. Using agency nurses has been a good way of managing that, because it brings in just the amount of staff that you need. I recall, from being a student nurse in the 1960s, that if a very sick patient was on a ward, we would have extra staff in to ‘special’ that patient, just for the time that we needed them. That is the sort of role that the use of agency nurses grew out of. We have had problems, of course, relating to the fact that using agency nurses, over time, has become an easy issue. The attitude was, ‘Oh well, we don’t have to think about how we balance out our ward staff or how we manage for annual leave and so on; we’ll just get agency staff in’. There was no single benchmark against which agency costs were measured, so agencies could charge what they wanted, and they would, particularly on high days and holidays, which were always extremely lucrative times for agency nurses to work. That is how we got to the situation of having a phenomenal agency spend, which had to stop, because we could not continue to do that.

[40] So, the all-Wales agency contract work group, whose work is explained here—I know that the Minister has published a Cabinet written statement on its success—is really beginning to pay off. This is new to Wales. I was in England in a major teaching hospital in the late 1980s/early 1990s and we were grappling with this at that stage, so it is late in coming to Wales. On that point, we can learn from what happened in England and how it has managed these contracts. It is now getting to grips with this, but the bottom line is that you will never completely get rid of agency utilisation.

[41] They are using their own bank of nurses in England. As a head of profession, I find that this is great on one hand, but I have concerns on another. In the report, I have stated that

nurses work in an extremely busy and, sometimes, very stressful environment. When nurses are working full time, and then working another shift on a bank, we have to be very careful about burnout and quality of care. However, by employing nurses from your bank, you get continuity of care, because they know the hospital and the patients, and you avoid the potential for patient care to fall down and slip between the cracks, from the point of view of using an agency.

[42] I am sorry, Jenny; what was your second point?

[43] **Jenny Randerson:** It was about whether you ought to count agency nurses as part of the vacancies, to put it in a nutshell.

[44] **Ms Kennedy:** I know that the Royal College of Nursing has strong views on the fact that there is a correlation between the utilisation of agency staff and the fact that establishments are not correct in the first place. We must sit down and look at our establishments, but we must start do so in terms of what nurses need to be doing and not what they have done historically. That might give us a different picture in terms of skills mix; reference has been made to this and you will be aware of the reports that have just come out that have focused on the relationship between mortality, morbidity and skills mix. I do not think that they should be routinely counted as part of the vacancies, but I understand the argument that the RCN is putting forward on that.

[45] **Jenny Randerson:** The third question was about the commissioning of training places.

10.00 a.m.

[46] **Ms Kennedy:** On that issue, we are going through a new round of workplace planning. Workplace planning is an inexact science and it has been driven by the secondary care sector, as I said before. It has been almost like a shopping list with a few add-on items year on year, and there has been a struggle over time to build meaningful information into that about changes in services. This year, we are trying hard with the new workforce development and education contracting unit, which has been set up within NLIAH, to look at proper approaches to workforce planning and design. As we stand, those figures have been through the NLIAH stakeholder board. The figures will be going through the partnership board before they come to the final decision-making commissioning board, which is chaired within the Welsh Assembly Government by Mrs Lloyd. That is where we will make the decisions.

[47] In terms of whether or not schools in Wales get later notification than is the case in England, I am afraid that I cannot say whether or not that is right. I do know that the pattern has been well-established. We start looking at workforce planning as early as April. We then work through the summer, and the budgets are usually known or determined around the tail end of the year in November or December. The universities are informed of their commissioning figures at the beginning of the next year. Part of the difficulty is that universities will recruit—we now have the university clearing house in any case—constantly, and it is extremely difficult. Every employer is looking for school leavers, and they are all trying to put them into potential courses that come up. We know that the whole outturn from A-levels means that they get their results at the end of August, which is quite late for them to start a course in October without having been offered places upfront. Central Government is looking at the issue of academic years and recruiting into education because of this problem.

[48] **Ms Donnelly:** What Rosemary said is absolutely right in relation to universities in Wales having to make recommendations to students when they want to come into training. Realistically, the universities in Wales are saying that the decisions taken by the workforce education contracting unit are happening quite late. I do not wish to rehearse the issues

regarding the budget from the National Assembly for Wales, but, nevertheless, that is impacting on the amount of training places that are likely to be within Wales. We have not seen the figures from the workforce development education contracting unit, which normally would have made its decisions—Rosemary is right that that is the process—but at the meeting two weeks ago those figures were not available because the budgets had not been set. The issue was raised at the stakeholder board by the universities, which said that they were unable to offer places to students without having some way of determining what their budget will be and the student numbers that they can offer. In real terms, because we have an all-graduate programme, it means that we are able to offer quite a number of degree places, and, as such, we have six applications for every place that we can offer, based on last year's figures of commissioning. That demonstrates that people in Wales want to take up nursing.

[49] So, recruitment to the training programmes is not an issue. It is an issue in determining whether or not these schools can offer places so that students can take up those places in September next year. Without the decision process, even with minimum figures, that creates a problem, because some students have also put in second and third applications for training places outside Wales, which those schools can offer sooner. However, to be honest, if we look at what is happening in England, those training places are being cut as well. So, if we are looking at figures, it would be very helpful if we could have a decision in Wales as to the amount of money that will be allocated to pre-registration education, so that the academic fraternity is able to make substantive offers to students. In that way, we can offer places to students who are domiciled in Wales to ensure that they stay in Wales on completion of training because that is where they are being given the opportunities to undertake the career that they have decided is important to them.

[50] Returning to the issue of the bank and the agency, this is touched on in the Chief Nursing Officer's report, and it has also been an issue for the college—I am happy to discuss this matter outside the committee or write to each Member. Nevertheless, we question the utilisation of agencies and the need for nursing input at whatever level, because, realistically, that has not produced a significant cost reduction; it has come down by about 2 million, but we are also seeing a corresponding increase in the use of nursing numbers across Wales. You could argue whether the whole-time equivalent figure is 2,500 to 3,000, or whether the headcount is 8,000, but that, too, depends on how many hours a nurse works.

[51] I agree wholeheartedly with the remarks of the CNO about the importance of workforce modelling as it affects the new agenda and the way in which 'Designed for Life' is determining that nurses need to look differently at their delivery of care in the community. But let us not get away from the issue; we currently have a degree of nursing in Wales that includes 50 per cent clinical practice, and of that, nurses do, and are trained to, work in the communities. Because of the fitness-for-practice initiative launched three years ago, we are content with the fact that new nurses are able to work either in the community or in the acute care sector. The difficulty that we have is where we are going to apportion post-registration qualification training to the existing nurses in the acute care sector, which will have to move from acute care out into the community. Again, workforce modelling needs to be done in that regard; Rosemary indicated the fact that some work has been done in west Wales, but there is also good work in south-east Wales and north Wales. Nevertheless, without knowing exactly what the configuration will look like, we are really concerned about the skills-mix ratio and the current workforce plans, which do not, realistically, take cognisance of the fact that the agenda is moving into the community. That creates concerns, in terms of public protection and the skills-mix ratio; yes, I will take it outside, because otherwise I will be going into royal college issues, and I do not want to do that, as this is the CNO's report. Nevertheless, I will write to you with regard to that.

[52] **Rhodri Glyn Thomas:** Byddem yn gwerthfawrogi nodyn at Aelodau.

Rhodri Glyn Thomas: We would appreciate a note to Members.

[53] **Jonathan Morgan:** I welcome the report, and I thank you for the details and the presentation. I hope that we have a chance to debate this matter in Plenary—it would be quite a good idea for other Assembly Members to place on record their thanks to the nursing profession and to say how much they value the role of the Chief Nursing Officer. Other Members, outside this committee, would welcome that opportunity. I flag that up at this stage.

[54] We have touched quite a lot on recruitment and retention so far, so I have just four brief issues to raise. The first relates to the increase in the headcount and the difference in the overall headcount to the increase in the number of whole-time equivalents. It seems that the increase in part-time nursing staff has increased at a greater rate than the increase in the whole-time equivalent. Is that historic, or does it merely reflect the changing pattern of work in the NHS? Are there particular reasons behind that, such as flexibility being created to enable people to work different shifts and patterns so that they can look after family and so on?

[55] You referred to the increase in retirement age; historically, it was 55 and now it is 65. Bearing in mind that a substantial number of people in the nursing profession will probably reach retirement age together, that will potentially create a recruitment gap. What challenge does that pose? How are we planning for that? I presume that it will not be rocket science, but I assume that planning is being done to fill that potential gap if it should appear.

[56] You referred in the document to the fact that, in England, there are concerns that a proportion of the nursing profession is not taking up posts after qualifying. What proportion of the profession in Wales decides not to take up a post on qualifying?

[57] Also, Tina mentioned some of the changing patterns of work, and the need to ensure that nurses working in the community are properly supported and trained, and that there is an infrastructure. Are we recruiting sufficient numbers of people to work in the community and, again, what sort of challenges does that present?

10.10 a.m.

[58] **Ms Kennedy:** Thank you for recognising the value of nursing. The issue of part-timers is extremely difficult. I have as many responses from our education providers as they were able to get on students who qualified in September and their first destination. However, at the end of the day, that depends on the students filling that in. There are indications that many of them are choosing the part-time option. We have seen an age-profile change among student nurses. In colleges and universities today, you will find a few mature students, shall I say, as opposed to school leavers and they obviously have different dependency requirements on their time. The part-time option is the one that they want to choose. Hopefully, the trusts are taking heed of the instructions given by Ann Lloyd previously on ensuring flexibility in workforce opportunities. However, I guess that some would like to opt for full-time and that is not on offer, so we are back to that point of affordability and the reconfiguration uncertainties.

[59] We talked about the head count and, on the retirement stage, at one time, nurses looked forward to being able to retire at 55 years of age. For some of us, just as we were about to reach 55, the age moved and became 60; just as we are about to reach 60, it has moved again and has become 65. Heavens, it could be a long time before we get to retire, could it not? This has proved quite difficult in terms of workforce planning. I hear and understand the universities' need to have figures early so that they can recruit into their posts earlier than they are perhaps doing at the moment. However, when you think that that recruitment is predicated on workforce plans that are around nine months in gestation, and you then add on to that three years of training, there are almost four-plus years between the

time you put up a commission idea and the time that you get a nurse out. During that time, as we see, significant changes occur.

[60] The change in the retirement age is a case in point. I was discussing the situation with an executive nurse in Bangor earlier this year and the September 2006 workforce plans were predicated on the fact that they thought that they had 15 to 20 people who were due to retire at this point in time, but who are not now going to retire. Let us be very honest: in some parts of Wales, the nurse, wife and mother may be the sole breadwinner within a family, so she will hold on to any opportunity to extend her working time. We used to gaze into a crystal ball and think how many people we were likely to lose, how many would retire and how many would move on to different things, but it is an inexact science, which is certainly having an impact. However, I have also said, in this report, that while it might be very good, and I am personally benefiting from the extension of retirement age, let us not forget that nursing is a very physically demanding profession and we need to be very clear that, if we are keeping nurses, their skills and historical experience, which we need, we must use them in ways that will not debilitate them. So, I hope that that answers your question on retirement.

[61] On the non-take-up after registration, that is very difficult to address, because no-one keeps data on that. We are debating, with our regulating body, the Nursing and Midwifery Council, how we track students and there are changes. We have concerns in Wales about the changes proposed by the Nursing and Midwifery Council for the quality assurance and monitoring of nursing education pre-registration. One of the things that we will be losing is the whole business of student tracking. When students finish their course, the university is set up to enable them to pass their registration application on to the regulator; however, whether they take up registration or not is another issue. If the students do not come back with their post-training report to say where their destination is, we do not always get to know it. The feeling in Wales, and this comes from the heads of the professions, is that, by and large, our nurses do register. We also have to be cognisant of the fact that since we went into the university clearing system—certainly since about 2003-04—we have had a lot of nurses coming from England to do their training because we offer degree training. Those nurses will go back to England and we just lose contact with them; we do not know whether they go into nurse training or not.

[62] Can we do anything about that? We can certainly do something about the first uptake and I think that the introduction of the electronic staff record is going to be fantastic, if we can get the right data collection through that system, in letting us know where starters and leavers are. I am pretty sure that the National Leadership and Innovation Agency for Healthcare, and the new workforce development unit, will want to consider linking that with the universities.

[63] In terms of community support, Tina mentioned that our current training is designed to enable a newly qualified nurse to practice in an institutional setting—a hospital and so on—and a non-institutional community setting. As long as they are part of a well balanced and supported team, we should be looking at taking newly qualified staff into formed community teams. However, in many cases, community nurses work in isolation and that is something that we have to bear in mind so that we do not release newly qualified staff into situations of increasing complexity. The nursing that you see in the community now requires experience and knowledge. There is a balance to be struck on that one.

[64] **Ms Donnelly:** That is a very important point.

[65] In relation to where they will be, post registration, commissioning figures come out of the workforce development education contracting unit. If we look at some of the figures that we currently have on that and the proposals with vacancies for district nursing that come from the tranche, you will see that there are lots of zeros. That goes back to my point with regards to workforce modelling. We need to have a realistic idea of what the skills mix should be, in

order to protect the public in the community. We need to know what the skills mix should be in terms of healthcare support workers at different levels and in terms of supervision, certainly within the first six months to a year post qualifying.

[66] Even more importantly, as Rosemary has already indicated, a lot of the nurses who were recruited three to four years ago were mature applicants—if I can say that, with the changes to the law on 1 October in terms of ageism—nevertheless, they were mature applicants to nursing and many of them wanted to take up part-time work. With that part-time work comes the issue of consolidation and the level of experience that are necessary to become even more competent practitioners, as their skills develop. Given that the CNO's report identifies that the acuity of patients who are being nursed in the community will increase, because it talks about the acuity of patients, we realistically need to have some idea and confidence that the commissioned figures that are to come out of the contracting unit will identify that district nursing, in terms of the supervisory role, needs to be enhanced and that we will then have adequate numbers trained.

[67] **Rhodri Glyn Thomas:** Diolch yn fawr. Dylai'r drafodaeth hon ddod i ben yn awr, ond gwn fod cwestiynau ychwanegol i'w gofyn, felly fy mwriad yw ymestyn yr eitem hon tan y toriad. Fodd bynnag, dylai aelodau'r pwyllgor fod yn ymwybodol fy mod yn bwriadu torri yn ôl ar yr amser sydd wedi ei briodoli i'r drafodaeth ar y gyllideb, oherwydd mae hynny allan o'n dwylo i raddau helaeth.

Rhodri Glyn Thomas: Thank you very much. This discussion should come to an end now, but I know that there are additional questions to be asked, therefore, it is my intention to extend this item until the break. However, committee members should be aware that I intend to reduce the time allocated to the discussion on the budget because that is out of our hands to a large extent.

10.20 a.m.

[68] Felly, bydd cyfle i chi godi pwyntiau ar y gyllideb, ond ni welaf llawer o bwynt i ni gael trafodaeth eang ar hynny, oherwydd mae hynny wedi symud ymlaen.

Therefore, there will be an opportunity for you to raise points on the budget, but I do not see much point in our having a broad discussion on it, because that has been moved forward.

[69] Yr hyn yr hoffwn ei wneud yn awr yw cymryd yr holl gwestiynau ychwanegol—gwn fod gan Helen a Jenny gwestiynau. Os gallwch ymdrin â hwy mor gryno â phosibl, byddwn yn ddiolchgar; os oes angen eglurhad ychwanegol, efallai y gallech wneud hynny drwy nodyn.

What I would like to do now is take all the additional questions—I know that Helen and Jenny have questions. If you could deal with them as briefly as possible, I would be grateful; if we need any further clarification, perhaps you could do that in writing.

[70] **Helen Mary Jones:** I have two sets of questions. The first set is on cleanliness. The report states that certain groups of staff are still resistant to change. Can you tell us which groups of staff those are, why they are resistant to change, and what needs to be done about it? You referred in your presentation to, for example, the need to develop ward management skills among nursing staff, and I am sure that that is true. However, when it comes to controlling the cleanliness of wards, to what extent can nursing staff exercise those ward management skills? Does more need to be done about having cleaning staff and support staff integrated into ward teams, so that the nursing staff can manage them? It is no good having the management skills if you are not allowed to manage that person, and you have to phone some other manager from somewhere.

[71] The other question is on nutrition. The report identifies the failure to protect meal times. Can you give us some idea why that continues to happen, because we would all want to

see that commitment? What are the pressures that lead to meal times not being protected, and what more could be done to relieve those pressures? It has been put to me that, where, for example, you have unfilled vacancies—or whatever a vacancy is—and you are therefore down on the numbers of nursing staff that you have on a ward, it becomes much more difficult to stop doing all the clinical work that you are doing to sit with patients and ensure that they are eating. That has been put to me anecdotally; I do not know whether that is the reason, but can we identify the reasons and what needs to be done to address those pressures?

[72] **Jenny Randerson:** I have a simple question. On the policy context, you list several documents, but you do not list the delivering emergency care services document. I know that that did not mention nursing much, which disappointed me greatly, but I would have thought that there was a large role for nurses in that regard.

[73] **Jonathan Morgan:** I have two quick questions on the clinical challenge. On page 20, you refer to school nursing and public health. Do you have the latest figures on how many school nurses we have in Wales, and how that number has altered in recent years? Do you believe that there should be plans for expansion, bearing in mind the rise in the number of young people with sexual health problems, the increasing rise in the number of adolescents with mental health problems, and the huge rise in the number of fat children in schools, and the fact that obesity and nutrition are now becoming an important set of problems that policy makers will have to contend with? There seems to be a strong reason there for an increase in the number of school nurses, who could be instrumental in helping to tackle some of those problems. I would like your thoughts on that.

[74] **Ms Kennedy:** I will try to be brief. On cleanliness, and which groups are resistant, somewhere along the line we seem to think that the only people who need to be taught to wash their hands are nurses, which is absolutely not the case. We are probably the best at washing our hands; the real problem comes from what I would call professional, casual visitors to the ward. These include—and I will say this—my medical colleagues. [*Laughter.*] There are also—and I am not trying to say that everyone is the same—other casual professional visitors, such as phlebotomists, who go from one patient to the next, taking blood. There is a range of staff who will have what they would consider to be minimal contact. Where people give hands-on care, they are alert to this; that would include physiotherapists, occupational therapists, and nurses, who are getting in there and doing something, as well as, possibly—let us hope—doctors when they are examining patients. However, when you believe that all you are doing is just moving on and doing a small, technical piece, or something, that is when we see real slip ups in this regard.

[75] What can we do? The ‘Clean Your Hands’ campaign—you can see the badge here—has invited patients to challenge and ask whether people have washed their hands before they touch them. Very few patients take this up. However, many trusts have a growing number of champions, including medical consultants. So, we are continuing to raise that. You will know that, in Wales, we are having some exceptionally good responses in terms of managing healthcare and hospital-acquired infection. The risk has reduced from around 10 per cent to around 6 per cent. So, we are moving in the right direction.

[76] On exercising ward management skills, the ward manager is the person who is key to managing the environment. It is that person’s responsibility to ensure that domestic services are there to meet the needs of the patient. It has been difficult when we have had contractors who have had set hours to clean a ward. However, all hospitals now have emergency teams who will come in and manage that. I would welcome seeing domestic and catering staff having an allegiance to a set of wards. I think that that ownership would make a huge difference. We have it in pharmacies, where there are pharmacists who have allegiance to and are attached to some wards. It works very well. Why not do this for other staff?

[77] I have a real beef about nutrition and protected meal times. We should stop looking in silos and start looking at the whole day of the patient in hospital. I still cannot understand why, for example, radiography departments call for in-patients at 11 a.m. or 11.30 a.m. to come down to the department to have their x-rays; they could just as well use that time for out-patients who have the opportunity to go and eat in a canteen at another time. It is about almost running a patient's diary and looking at when they wake up, and at the fixed points in their life. Meal times are exceptionally important, as are sleep and rest times. As far as possible, apart from emergencies, you should work your diagnostics and treatment around them. Similarly, we may have to take the bull by the horns and tackle the problem of the opening up of wards to endless visitors at any time of the day or night, when the patient feels obliged to entertain their visitor, instead of having a protected time to get on with their meal. I hope that that has answered your questions.

[78] **Helen Mary Jones:** On the issue of visitors, some of the families that I have spoken to feel that they have to visit at meal times as they are the ones who feed their elderly relatives, because the nursing staff and support staff are not there to do it. So, I agree that the time should be protected, but you make the point in the report about essential visitors; for some frail, elderly patients, the son or daughter who is putting the food in their mouth because there is no member of staff who can or will do it, can be regarded as people who absolutely need to be on the wards at meal times at the moment. Perhaps they should not need to be, but the truth is that, in many places, they do.

[79] **Ms Kennedy:** In some instances, having the relatives there to assist with feeding is a good thing and I would wish to encourage it. However, if they feel obliged to do that, we have real problems that we have to sort out.

[80] In terms of policy context, Jenny, delivering emergency care services was not listed. The DECS consultation has just ended. I was at a meeting with representatives from the Chief Medical Officer's office and from the trusts and the ambulance service looking at the responses to DECS. Many of the comments and the changes are now being imported into a rewrite of that. Many issues were raised about the role of nurses and I anticipate that that will be addressed the second time around.

[81] On school nurses, you will be aware that the Minister agreed that we would have a cross-Assembly working group with colleagues from education and public health to look at the role of school nurses and what it is that they are supposed to do. We know that they are no longer the nit nurses; they have a huge role to play in supporting young people. We are keen that this is not seen as a school-nurse service but a school children's health service, the health of school-aged children, that runs not as a system that school nurses might do only in term time but right across the whole piece. So, we are having to go back to look at what we would need in terms of numbers. Chris Tudor-Smith is chairing a group that will be looking at that, and we also have our networks involved in that. The work of Pembrokeshire and Derwen NHS Trust that I illustrated was because it had worked with local authorities, schoolchildren and parents, asking, 'What do you want of our school health services?', and that is a very good starting point.

10.30 a.m.

[82] **Ms Donnelly:** In relation to the review of delivering emergency care services, I could not let this meeting go without my commenting on that. I know that I have already spoken to the Minister and to several members of the committee here. Realistically, the emergency care collaborative is supposed to be dealing with some of the violence and aggression issues, and the chief nursing officer did discuss with us whether violence and aggression towards nurses should be included in this report. If you have a complete strategic document or a vision—and

I cannot work out what DECS is, at present—we would expect the violence and aggression that health staff are coming up against to be addressed within that, as it is a real problem for nurses.

[83] The other issue in relation to the emergency care collaborative has already been mentioned, and is in regard to nursing. It is remiss of that document not to comment on the amount of work that nurses in Wales did to inform that report. It beggars belief that they did not even get an acknowledgement on the back page along with the other bodies and individuals who contributed to that report. Realistically, I am looking forward to that report coming out with a potential rewrite, looking at the roles that nurses can play. The front-line services have identified that they are willing to take up the challenge and run with 'Designed for Life' and the issues that have to come into play when dealing with patients in an acute emergency.

[84] **Rhodri Glyn Thomas:** Diolch yn fawr am yr adroddiad cynhwysfawr. Yr ydym yn ddiolchgar iawn hefyd am yr ymateb i'r cwestiynau a'r sylwadau. Yr oeddwn yn awyddus i sicrhau ein bod yn cael trafodaeth lawn ar hynny. Diolch yn fawr i'r pedair ohonoch am ddod atom heddiw.

Rhodri Glyn Thomas: Thank you very much for the comprehensive report. We are also very grateful to you for responding to our questions and comments. I was keen to ensure that we had a full discussion on this. I thank all four of you for attending this morning.

[85] Mae'n briodol imi eich hysbysu fod Linda Davies o Gwmllynfell yn yr oriel. Mae'n cysgodi Ann Lloyd ar hyn o bryd, ac mae ar raglen arweinyddiaeth y Coleg Nyrsio Brenhinol. Felly, estynnwn groeso arbennig iddi.

It is appropriate that I also inform you that Linda Davies from Cwmllynfell is in the public gallery. She is currently shadowing Ann Lloyd, and she is on the Royal College of Nursing leadership programme. We extend her a warm welcome.

[86] Fe dorrwn am egwyl yn awr. Gofynnaf ichi ddychwelyd am 10.45 a.m. ac fe gymerwn y materion am yr is-ddeddfwriaeth bryd hynny.

We will now take a break. I ask you to return by 10.45 a.m. so that we can take the issues on subordinate legislation then.

Gohiriwyd y cyfarfod rhwng 10.33 a.m. a 10.48 a.m.
The meeting adjourned between 10.33 a.m. and 10.48 a.m.

Is-ddeddfwriaeth: Rheoliadau'r Gwasanaeth Iechyd Gwladol (Diwygiadau Amrywiol Ynghylch Nyrsys sy'n Rhagnodi'n Annibynnol, Rhagnodwyr Atodol, Nyrsys-ragnodwyr Annibynnol a Fferyllwyr-ragnodwyr Annibynnol) (Cymru) 2007; Rheoliadau'r Gwasanaeth Iechyd Gwladol (Rhagnodiadau am Ddim a Ffioedd am Gyffuriau a Chyfarpar) (Cymru) 2007; a Chyfarwyddiadau'r Gwasanaeth Fferyllol (Gwasanaethau Uwch a Gwell) (Cymru) (Gwelliant) 2006
Secondary Legislation: The National Health Service (Miscellaneous Amendments Concerning Independent Nurse Prescribers, Supplementary Prescribers, Nurse Independent Prescribers and Pharmacist Independent Prescribers) (Wales) Regulations 2007; the National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Wales) Regulations 2007; and the Pharmaceutical Services (Advanced and Enhanced Services) (Wales) (Amendment) Directions 2006

[87] **Rhodri Glyn Thomas:** Symudwn

Rhodri Glyn Thomas: We will now move to

at yr is-ddeddfwriaeth, sef eitemau 3, 4 a 5. Bwriadaf eu cymryd gyda'i gilydd, oherwydd nid oes gwelliannau iddynt. Codwyd pum pwynt o eglurhad gan Jenny Randerson o ran eitem 3, ond mae'r Gweinidog eisiau dweud gair yn gyntaf.

the secondary legislation, which are items 3, 4 and 5. I intend to take all three items together, given that there are no amendments. Jenny Randerson has raised five points of clarification on item 3, but the Minister wants to introduce this item.

[88] **The Minister for Health and Social Services (Brian Gibbons):** I do not want to deal specifically with the general regulations, but I would like to thank my officials who have worked very hard to get these regulations here, particularly the medicines use review regulations in line with the work that we have been doing with the pharmaceutical profession. Equally, I thank Community Pharmacy Wales for the help that it has provided in going through these regulations; it has made some useful observations that have been positively received.

10.50 a.m.

[89] As the Assembly moves towards taking a more legislation-based approach after May next year, I think that we will need that detailed assistance from other organisations, to give us the cutting edge necessary to improve our legislative skills. So, our thanks are due to the officials who have worked hard to get us where we are. At one stage, we did not think that some of these regulations would be here before Christmas, let alone before the end of November, so I thank them. I am happy to proceed, Chair.

[90] **Rhodri Glyn Thomas:** Yn sicr, yr ydym yn ategu ein gwerthfawrogiad ni o'r gwaith yr ydych wedi ei wneud. A oes unrhyw sylwadau cyffredinol cyn imi droi at Jenny a'i phum pwynt o eglurhad?

Rhodri Glyn Thomas: We would certainly add our appreciation of the work that you have done. Are there any general comments before I turn to Jenny and her five points of clarification?

[91] **Helen Mary Jones:** This is just a question that the Minister or his officials may be able to respond to. I am glad to see the regulations, and I think that we would all say, 'At last' and 'Well done'. However, while we have been going through the complex process of getting the legislation ready, what preparatory work has been undertaken to facilitate its implementation? Once the regulations are enacted, are organisations ready to implement them straight away? I know that there have been issues in England where the right decision-making structures were not in place, particularly around nurse prescribing, so are we confident that, once the law is passed, the service will be able to deliver?

[92] **Brian Gibbons:** Are you talking about independent prescribing?

[93] **Helen Mary Jones:** Yes.

[94] **Brian Gibbons:** This will be a commissioning decision in the local areas, and, while the situation with the pharmacists may be slightly different from that with the nurses, essentially, it will be a commissioning process. It is not fair to say that we are in a position to give a precise answer to the question of how many independent pharmacy prescribers or how many independent nurse prescribers there will be at the end of the year. However, we are training 150, and some 400 to 500 nurses have been trained as supplementary prescribers and so forth to date. However, exactly how many of those will end up on the front line, issuing prescriptions in line with these regulations, I do not know, and I do not think that we can give you a figure.

[95] **Helen Mary Jones:** My point is whether the commissioners are ready. We know that the training is in place. It may not be possible for him to respond today, but perhaps the

Minister could give us a note on what is being done with the commissioners to get them ready to take the opportunity once people are trained and so on.

[96] **Jenny Randerson:** May I clarify something with you, Chair? I thought that we had to put our comments in by Friday. If we are not going to operate that system, we might as well be told that. Labouring through something the week before is always an extra effort.

[97] **Rhodri Glyn Thomas:** Our problem is that you have identified these pieces of legislation to come to committee, and the only five points of clarification that have come in were from you, which is why we took—

[98] **Jenny Randerson:** I would assume that that meant that other people were not bothered.

[99] **Rhodri Glyn Thomas:** That is why I asked for general comments. You identified these points, and to identify them but not to raise issues on them would be strange. We will move to your points of clarification.

[100] **Jenny Randerson:** The Minister has already answered one. I asked what proportion of nurses and pharmacists are on the register, and what plans there are to increase the numbers registered. I also asked what plans he has to advertise the availability of extended prescribing, because the issue is very much one of patients being aware that this opportunity exists but that it will not apply to all drugs. It is a complex area, and information has to get across to people. In addition, on the financial implications paper that we have, is the Minister sure that the additional costs can be accommodated in the supplementary prescribers budget, or does he intend to increase that next year? If this is going to work, it will cost more. I also asked—

[101] **Brian Gibbons:** Well—

[102] **Jenny Randerson:** Do you want to answer them one at a time?

[103] **Brian Gibbons:** Yes, please.

[104] **Jenny Randerson:** I am sorry; I thought that we were rushing through this.

[105] **Rhodri Glyn Thomas:** We have the five points of clarification on paper 02b. We will take them one by one.

[106] **Brian Gibbons:** The first question that Jenny asked was about the proportion of nurses on the register. That is difficult for us to answer, because the registers are not held by the Assembly. There is a UK register, just like the General Medical Council or nursing registers, so we do not have that information, short of interrogating that register fairly laboriously. However, as I have said, we know that 400 to 500 people have gone through the training programme, but we do not know whether they have applied to have that put against their name on the register. Equally, we do not know precisely how many of those 400 to 500 people are prescribing as supplementary prescribers. It has been suggested that the supplementary prescriber is too restricted in terms of having to work to a management plan and so forth, whereas an independent prescriber has much more professional autonomy and, if the management plan is not there, has the preconditions. So, it has been suggested that supplementary prescribing operated, to a certain extent, within a straitjacket and that some of these 400 to 500 people who do the conversion course may come back and become more active in this area, compared with what they are doing at present.

[107] **Jenny Randerson:** Okay. What about the advertising?

[108] **Brian Gibbons:** I do not think that it is going to be advertised in the sense that there will be advertisements on the television or in the local paper or anything like that, but I would imagine that, as pharmacists redesign their services, they will, in some way, advertise the fact that they have an independent prescriber in their pharmacies. For example, in several Valleys practices and, presumably, elsewhere too, nurses run minor illness clinics and patients have the choice, when they present at the surgery, to go to that minor illness clinic; equally a nurse can run a chronic disease clinic in a surgery. I also expect that, if a pharmacist is going to become an independent prescriber in that way, he or she would have to communicate with the local health board to ensure that it was happy with that. However, it is not going to be a big-bang launch with balloons and a fanfare and so on; it will be much more incremental and will be assimilated into the normal work patterns.

[109] **Rhodri Glyn Thomas:** What about the additional costs—point 4?

[110] **Brian Gibbons:** We are fairly happy with that. We are operating on the assumption that there will not be a massive explosion in the number of prescriptions being prescribed under the free prescription scheme and, equally, in terms of where patients will decide to access their treatment. We have given a 7 per cent uplift under the pharmacy heading in the draft budget, so we hope that that will be sufficient to accommodate the costs of any extra drugs that will be prescribed and we are quite happy that this scheme's training requirements will be met within the budget that we have allocated. We are reasonably happy with that.

[111] **Rhodri Glyn Thomas:** What about the optometry-related prescriptions?

[112] **Jenny Randerson:** I will just ask a supplementary question, if I may. So, not all prescriptions by independent prescribers are going to be paid for, are they? Is it going to be the case that there will be free prescriptions on the NHS next April but that those being done by independent prescribers will have to be paid for?

[113] **Brian Gibbons:** It will be up to the patient to decide. It is one of the imponderables at this stage as to whether or not people will decide to buy over-the-counter medicines or will avail themselves of the free prescription. However, if there is a dispenser in a pharmacy, the patient will be in a position to exercise a choice as to whether he or she pays for that prescription or whether he or she wants a free prescription, depending on the circumstances. That goes on in dentistry, for example. Very often, there is free dentistry but people choose to have a private dentist. So, people do exercise choices in these circumstances.

[114] **Jenny Randerson:** I understand that, but I was not aware of this, Chair—I must have been asleep somewhere. Are you saying then that, if you go to your local GP practice where there is an independent nurse prescriber, that independent nurse presciber will only be able to give you a prescription for which you would have to pay?

11.00 a.m.

[115] **Brian Gibbons:** No. The prescription will be free. If you go to a pharmacist who is an independent prescriber, he or she will be able to give you a free prescription. That is the point that I thought you were trying to make. If you go to a pharmacist who is not a prescriber, that pharmacist will be able to give you standard advice, and you will then have to buy an over-the-counter remedy if you want to get something from that pharmacist. If the pharmacist is an independent prescriber, then you will be in a position to get a free prescription or, if you want, you can buy over-the-counter medicine. I accept that most people will take the free prescription—that is human nature. I am just pointing out that, in something such as dentistry, people still have the choice between an NHS dentist and a private dentist, and some people choose private dentistry, even though NHS dentistry is available to them.

[116] **Jenny Randerson:** Optometry is excluded, is it not?

[117] **Brian Gibbons:** Up to now, optometrists have been able to prescribe in some areas, but they have not been able to prescribe on the NHS. They have had limited prescribing rights, but outside the NHS context. This is therefore designed to allow optometrists to come into the NHS family with regard to prescribing. That will bring free prescriptions into effect under that heading. If we did not do this, optometrists would be able to issue a private script. Do any of my colleagues want to elaborate on that?

[118] **Ms Evans:** Just to mirror what you said, optometrists cannot currently prescribe on the NHS, but we are advocating that they become part of the supplementary prescribing allied health professionals, which will enable patients to access their services and be able to get an NHS prescription from an optometrist, which they cannot currently get.

[119] **Jenny Randerson:** What is the difference between an independent nurse prescriber and a nurse independent prescriber?

[120] **Brian Gibbons:** Before last night, I did not know, so I am going to see now if I have done my homework and can remember. One is the definition of people who can prescribe from a limited list. At the moment, nurses can prescribe bandages, dressings and a limited number of items, and those are independent nurse prescribers, whereas nurse independent prescribers are the people whom we are covering in these regulations.

[121] **Rhodri Glyn Thomas:** Diolch yn fawr, Weinidog, a marciau llawn am eich gwaith cartref. Diolch hefyd i'r swyddogion.

Rhodri Glyn Thomas: Thank you very much, Minister, and full marks for your homework. Thanks also go to the officials.

[122] O ran cwestiwn Jenny Randerson, os oes darnau o is-ddeddfwriaeth lle na chyflwynir pwyntiau o eglurhad na gwelliannau ymlaen llaw, byddant yn cael eu cynnwys fel papurau i'w nodi yn y dyfodol, ac nid fel eitemau ar yr agenda. Os ydynt yn eitemau ar yr agenda, mae'n rhaid imi roi'r cyfle i Aelodau fynegi barn yn eu cylch. Fe ddilynwn y drefn hon er mwyn cydnabod yr Aelodau hynny sydd wedi gwneud y gwaith caled o fynd drwy'r ddeddfwriaeth a chodi pwyntiau o eglurhad neu welliannau.

With regard to Jenny Randerson's question, if there are any pieces of secondary legislation for which points of clarification or amendments have not been tabled in advance, they will be included as papers to note in future, and not as items on the agenda. If they do form items on the agenda, we are obliged to allow Members to air their opinions on them. We are taking this approach to recognise those Members who have done the hard work of going through the legislation and have raised points of clarification or amendments.

11.04 a.m.

Craffu ar y Gyllideb
Scrutiny of the Budget

[123] **Rhodri Glyn Thomas:** Yr ydym wedi cael trafodaeth eisoes wrth baratoi ein blaenoriaethau ar gyfer y gyllideb. Nid wyf am ailadrodd y drafodaeth honno—ymateb ydym yn awr i'r gyllideb a'r hyn y mae'r Gweinidog wedi'i wneud. Wrth reswm, ni fydd yn ymateb i bopeth a godasom. Diolchaf iddo yn benodol am yr arian

Rhodri Glyn Thomas: We have already had a discussion while preparing our priorities for the budget. I do not want to repeat that discussion—we are just responding to the budget and to what the Minister has done. Of course, he will not be responding to everything that we raised. I thank him in particular for the additional funding that he has allocated to

ychwanegol y mae wedi'i glustnodi ar gyfer gwasanaethau canser—mae hynny'n gydnabyddiaeth o'r ffaith ein bod yn cynnal arolwg o hynny ar hyn o bryd, ac yr ydym yn ddiolchgar iddo am gydnabod hynny. Nid yw'n swm enfawr, Weinidog, a gobeithio bod hyblygrwydd yn y gyllideb ar gyfer mwy o arian, os yw ein hargymhellion yn mynd i'r cyfeiriad hwnnw. Felly, fe godwn y pwyntiau o ran ymateb i'r Gweinidog, ac erfyniaf arnoch eto i beidio â thrafod yr hyn y gwnaethom ei drafod wrth baratoi'r pwyntiau hynny.

cancer services—that is in recognition of the fact that we are currently conducting a review of those services, and we are grateful to him for his acknowledgement of that. It is not a great sum, Minister, and we hope that there is flexibility in the budget for more funding, if our recommendations go in that direction. Therefore, we will raise the points in terms of responding to the Minister, and I ask you once again not to return to the debate that we had in preparing those points.

[124] **Lynne Neagle:** The Minister will not be surprised to hear me ask about the Townsend formula. There is no reference in the Minister's paper to the formula. It is the second or third year in which the committee has included this as a budget priority, so I wanted to ask for clarification on what the situation is, and whether any funding has been earmarked. I realise that it will not be in the top-line figures, but when the Minister was scrutinised on this issue he indicated that he had worked on the basis of funding manifesto commitments and so on, and had then allocated money to the Townsend formula. I assume that a similar assessment has been undertaken. So, may I have some clarification on that?

[125] **Rhodri Glyn Thomas:** A gaf innau hefyd ategu'r pwynt ar fformiwla Townsend? Mae'n effeithio ar sir Gaerfyrddin yn drwm, ac mae'r mater hwn wedi cael ei godi yn y cyngor sir yn ddiweddar. A oes unrhyw un arall eisiau gwneud sylw ar fformiwla Townsend?

Rhodri Glyn Thomas: May I also endorse the point on the Townsend formula? It has a considerable impact on Carmarthenshire, and this issue has been raised recently in the county council. Does anyone else wish to comment on the Townsend formula?

[126] **Helen Mary Jones:** I just wish to support what Lynne said.

[127] **Jenny Randerson:** I have a point regarding whether the Townsend formula has been used in the allocation of the drugs budget. It was announced some time ago that that is how it would be done; is that how it is being done this year?

[128] **Brian Gibbons:** We have reported on a number of occasions that the transition from the old Welsh health survey to the new health survey, and the application of that to the Townsend formula, is an ongoing process. We are still not totally happy with the resilience of that process. We asked the University of York to undertake further work on that, and it has produced an interim report and a full report on that. The reports went to the expert group, which we have in-house, to decide on this issue in terms of practical policy application. Even with the expert group, we are still not at a stage to say that we are totally happy that we have a robust set of arrangements to implement the Townsend formula. However, we are looking at interim measures that might make small incremental progress towards implementing the Townsend formula, to maintain the momentum rather than to come to a complete halt on the allocation method.

[129] Until we have more certainty about the Townsend formula, it is important that we do not transfer a large sum of money to different LHBs on the basis of what may be an imperfect tool, and then find ourselves next year taking that money back again because the decisions were not as strongly evidence-based as we would have liked. From my point of view, we cannot move quickly enough towards the Townsend-formula approach, not least because my own constituency would be a beneficiary. The Chair is right that places such as

Carmarthenshire are probably areas where there will be a beneficiary in most circumstances. However, other communities are much more marginal, and the instability of giving them a sum of money this year and taking it away next year is not to anyone's benefit. However, we are looking at some type of ad-hoc arrangement this year to try to maintain the momentum, but we must be happy that we will not create more problems than we are hoping to solve. That will be in the general LHB allocation, so it will not be a Townsend-formula, ring-fenced sum in the way that Lynne might have suggested.

[130] **Rhodri Glyn Thomas:** It would be useful for those LHBs, where it is clear that there is a substantial deficit, if you could work on an ad-hoc basis so that they get at least some recognition of the deficit. That would help us, and we would urge you to try to come to a conclusion on this matter as soon as possible, because it has been raised several times in committee. Did you want to come back on that, Lynne?

11.10 a.m.

[131] **Lynne Neagle:** Yes. The Minister referred to money being allocated via an imperfect tool, but those of us who represent Townsend-gain areas would argue that that has already been happening for years and years. We have never had any problem giving money under the old formula, which has been found to be inadequate, yet there is all this hesitancy about moving to a formula that we spent years developing with an international expert on poverty chairing the group. We must be mindful of the timescale here. It has been some five years since this started. We are now into a period of further delay. We are talking about the budget round for next April, so could the Minister give any indication of when he would be making some sort of decision on this? I also request a further update on this in the next Minister's report, perhaps when the local health board allocations are known. The situation is very worrying and I place my concerns on record.

[132] **Rhodri Glyn Thomas:** The Minister did say that he was looking at ad-hoc arrangements for the next financial year and I am happy to request that he refers to that in the next Minister's report and perhaps we can have some time to consider Townsend in the next meeting.

[133] **Jonathan Morgan:** My point is not on Townsend, but on the drugs budget, which was mentioned in the context of Townsend. You said that there was an increase of around £35 million in the drugs budget for the 2007-08 financial year. Therefore, how much would the drugs budget have been had you not removed roughly £30 million from it a year or so ago? Some £36 million was taken out of that budget and transferred into the central budget expenditure line. So, it appears that you are merely replacing what you took out in the first place. I know that, when looking at this budget line, there seems to be a dramatic and wonderful increase in the drugs budget, but all you are doing is replacing what you had removed in the first place.

[134] **Rhodri Glyn Thomas:** Does anyone else have a question on the drugs budget before we move on from the Minister's report? I see that you do not.

[135] **Brian Gibbons:** That is a fairly typical question. All I know is that we were able to make considerable savings through reclassification—through category M drugs—and the actual costs for the same basket of drugs decreased fairly substantially because of that. So, there was no cut, in effect, in relation to the provision of drugs to the front line. They simply cost less and, working from that baseline, the increases have been calculated. I do not know whether Steve wants to add to that.

[136] **Mr Elliot:** That funding was used primarily to support the pharmacy contract, which is why it had to be moved from one budget line to another. So, although, it looked like a

reduction in the drugs budget, it was actually category M savings that were primarily used to support the new pharmacy contract. That was similar to the approach also taken in England.

[137] **Helen Mary Jones:** I have two points. First, on ambulance funding, the committee has welcomed the additional money that the Minister has provided, but we have expressed concern that it may not be enough. In his report, the Minister states that he has agreed to consider other capital bids from the ambulance service in support of the modernisation agenda. If he gets those bids, where will that capital money come from? I think that we can anticipate that. You also say, quite rightly, Minister, that you are waiting for the business case. Do we have an idea of the timescale for that business case?

[138] I have an additional question on children's services. Do you want me to come back to that?

[139] **Rhodri Glyn Thomas:** Let us address the ambulance service question first. No-one else has a question on that.

[140] **Brian Gibbons:** It will be a bid against the capital programme just like any of the other bids and will presumably be on the back of the modernisation programme that will hopefully go before the ambulance trust board in December. I do not know whether the board will accept it, but it will, hopefully, be signed off then, because at least three or four months' worth of work has gone into that capital budget, but Ann can comment further on that.

[141] **Ms Lloyd:** We have made space available in the capital investment board in January and February to receive these bids and I have told Alan Murray that we expect these bids to be firmed up. They have been in production for some considerable time, but he has taken a renewed interest in those, because they fit in so well with his modernisation plan. The one area about which we had concerns was the radio replacement programme; because this is an England and Wales programme, it was supposed to be funded from capital in the first instance and then it was capitalised, so it became revenue. We have secured the resource to help the ambulance service out in terms of the revenue requirements, which is a real improvement on the position that we were in.

[142] **Helen Mary Jones:** On the budget for children's services, Minister, you account for the decrease by saying that this is a transfer of money into the revenue settlement. I want to express concern about that, Chair, particularly with regard to the extra money for fostering. I know that, historically, many of us are not very comfortable with ring-fencing local authority money, because we do not want to reduce local autonomy, but when it comes to money for children's services, the more that goes into the general pot and the less that is specifically allocated, my concern is that the best authorities are doing their best on foster care, but this money will simply disappear off somewhere else in the authorities that need to be brought up to scratch.

[143] Particularly with regard to the additional support for foster carers, there will be a consultation shortly about setting a national minimum allowance. My concern would be that if that money just goes into the overall revenue settlement, it may or may not be made available to foster carers and the children. I know that there are issues around this and that some counties pay much better than others. We have a situation in those counties that do not pay very well where we are losing foster carers to the private sector, which ends up being much more expensive for the local authorities that then have to use those private sector providers. I would urge the Minister to look again at how that extra fostering money will get to the local authorities and whether we need—again, this is controversial—to target some source of money specifically at those authorities that are falling back and perhaps might not meet the national allowance when you set it. I know that it is a difficult and controversial issue, but it is a different matter when it comes to children's services.

[144] If we had a special grant, let us say for a year, that got all the authorities up to a certain standard, once that statutory minimum was set they would not be able to drop below it and then it would be safe to put the money into the overall revenue. I am also concerned that it is a very small amount of money and we would obviously like to see more specific money for foster carers. However, I am worried that even that amount of money, as it is, will disappear. I have said my piece, Chair, and I do not know whether the Minister can respond to it.

[145] **Rhodri Glyn Thomas:** Does anyone else wish to come in on that point on children's services? Minister, do you want to respond?

[146] **Brian Gibbons:** Yes. On Helen Mary's last point, I am always a little nervous about specifically targeting people who are not delivering at the moment, because that is an incentive to do nothing. If you let the innovators go on and take a hit and then when you try to introduce a service universally it is only the laggards that get any money, that is not acceptable. However we do it, I do not think that there should be a perverse incentive in the system that the people who under-perform should be the people who get the extra resource allocation.

[147] **Helen Mary Jones:** I understand that, Minister, and, overall, I would agree with you, but in the end, it is the foster carers and the children who are suffering. It is more important that those children are properly looked after than that we slap some local authorities across the wrists because they have not behaved properly.

[148] **Brian Gibbons:** We know that 14 of the 22 local authorities have managed to give fostering allowances up to and above the standard that we are suggesting in the proposed consultation document, to which you referred. There will clearly be a difference of opinion on this. However, I think that we need a system in which the people who deliver the best services are incentivised, rather than us incentivising people who are not shaping up or being dynamic or proactive enough. We are clearly not going to agree on that.

[149] If the consultation is in favour of the minimum fostering allowance, we will have to look at the budget implications of that. We estimate that bringing that in will cost just over £1 million. We will have to take a view as to how the money will be distributed. I am always nervous about a system of allocation that incentivises underperformance and does not recognise the people who get on with it.

[150] **Rhodri Glyn Thomas:** Ar y pwynt hwn, Karen Sinclair.

Rhodri Glyn Thomas: On this point, Karen Sinclair.

11.20 a.m.

[151] **Karen Sinclair:** I do sometimes wonder—we did not take that view when some of the trusts were overspending some years ago. In the end, this is about children, is it not? It is important that we get that right. We should hypothecate this money for children's services on an ongoing basis; the history of children's services is nothing that we should be proud of. We should be proactive in saying, 'We ring-fence this, and we ensure that we up this service'. I would be more than happy to get behind that.

[152] **Brian Gibbons:** In many instances when we introduce a new requirement, and we want to ensure that it is bedded-in, it will start off on the basis of a special grant. That is well-established practice.

[153] **Helen Mary Jones:** That is exactly what I am asking.

[154] **Brian Gibbons:** Yes, but a special grant can go to everyone—that is my point.

[155] **Helen Mary Jones:** I would welcome that, but, if you are going to do it for everyone, then to get everyone up to the standard, you are going to need to put more money in. Therefore, a special grant by all means, but—

[156] **Brian Gibbons:** I said that already—it will probably cost over £1 million to bring this up, so we realise that there is a financial element in this; no-one is disputing that.

[157] **Helen Mary Jones:** Could the Minister—perhaps in a report—also give us an update on the progress on the consultation at some point?

[158] **Rhodri Glyn Thomas:** Mae'r cais hwnnw wedi ei wneud.

Rhodri Glyn Thomas: That request has been made.

[159] **Brian Gibbons:** I have seen the document, but I do not believe that it has been circulated yet. However, the fact that it has come over my desk, and that I have had a view of it, means that it is at a fairly advanced stage. It will certainly be available sooner rather than later.

[160] **Jonathan Morgan:** Briefly, on NHS allocations, what proportion of the additional £139 million that is allocated to the budget expenditure lines for the trusts and the LHBs has come from the general uplift in the budget, and what proportion has come from other budget expenditure lines?

[161] Secondly, in the current financial year, you awarded trusts a proportion of funding to cover their local delivery plans in readiness to meet the 2009 targets. Has that money now been built into their budgets for future years, or is there ongoing, additional money, in addition to the budget, that they will receive for 2007-08? I am concerned that, unless that money is in addition to the money that is awarded to them for the 2008 financial year, they may struggle to find that money to help the trusts meet the Assembly Government's requirements for those targets.

[162] If you examine the 8.2 per cent increase in the budget of the NHS trusts and LHBs, how much of it is a growth budget, when you take into account the rate of inflation and additional, ongoing costs to trusts, in particular the consultant contract and the continuing problems with 'Agenda for Change'? While it looks healthy, how much of that, in reality, is an actual growth budget?

[163] **Brian Gibbons:** Steve can deal with Jonathan's more technical points; I will deal with the local delivery plans. The local delivery plans are outside this—they are still a ring-fenced, separate allocation, and that is, again, allocated against performance, and so on. Therefore, that is being monitored and delivered outside the main NHS allocation. Could you deal with the technical points, Steve?

[164] **Mr Elliot:** Most of the transfer of funding into that budget expenditure line was a recurrent effect of what has already been agreed for this financial year, and was reflected in the in-year budget transfer paper that was brought to committee earlier this year. It provides us with the ability to cover an uplift on the LHB line; we are still working through the detail of exactly how much that uplift will be, but we are working closely with LHBs and trusts to ensure that, as far as possible, we can meet their cost increases this year. That will include some additional funding to reflect the incremental costs of 'Agenda for Change', because 'Agenda for Change' has a ramping up effect over several years, and we reflect that as part of this overall uplift.

[165] **Jonathan Morgan:** Can you tell me how much of the £139 million is a restating of what was the current in-year transfer in the present financial year?

[166] **Mr Elliot:** The additional funding that we have received as part of this year's budget planning round is just £16.9 million. So, the remainder of that transfer is, effectively, making recurrent what has already been actioned as part of this current financial year.

[167] **Jonathan Morgan:** So, £16.9 million is new money and the other £120-odd million is merely a restating of what was already decided for the present financial year?

[168] **Mr Elliot:** Yes, but it provides the funding to create an uplift again for 2007-08.

[169] **Jenny Randerson:** I would like to raise a few workforce issues, one of which is 'Agenda for Change'. The gap in 'Agenda for Change' money was around £17 million, which was due to a Treasury miscalculation. I believe that officials previously said that there was a strong possibility that this would be repaid. Has it been repaid? If not, are there negotiations about whether this will be repaid? That is the normal way in which the UK Government deals with us: if it makes a miscalculation, we get recompense. I believe that this relates to the Audit Committee's discussions on this subject. I have a second question on the workforce. The education and training budget expenditure line increases by £12 million while the workforce development central budget decreases by £16 million. Am I right in assuming that you are swapping things from one to the other? Even if that is the case, that seems to be £4 million less for workforce development overall. I have some concerns about there being less money for workforce development, especially in light of some of the discussions that we had earlier this morning.

[170] **Brian Gibbons:** Again, I will ask Steve to deal with the workforce issue.

[171] The error is not of a nature that the Treasury probably is going to—it is our analysis of the situation as to why we have had the shortfall in terms of the calculation. Whether or not it feels that the nature of the error is such that it feels obliged to repay the money is another issue completely. The error crept in because a payment was not made for hours that had already been paid for because of holidays and so on. It is a fairly complex issue. However, I know that Ann dealt with this in the Audit Committee. It might help if she were to clarify that once again for this committee.

[172] **Ms Lloyd:** The shortfall has occurred because, as the Minister has said, the calculation was based on the paying out of floating bank holidays, as we call them. However, unfortunately, I do not think that Department of Health officials realised that most of us had done that many years ago. So, two days were not included in the calculation, which amounts to our £17 million. The Department of Health has told us that it will not use any of its resources either to bail out itself, or us. So, we have flagged it up to the Treasury, noting that this was a genuine error made by the negotiators for 'Agenda for Change', namely the Department of Health. The case has gone to the Treasury. We do not know how sympathetic it will be, but we have warned the service that we think that it is unlikely that, after this length of silence, we will get any further moneys and that they need to start implementing their benefits realisation programmes pretty sharply in order to be able to close the gap on the £17 million.

[173] **Brian Gibbons:** This is not a Wales-only issue; this affects the general negotiation. I do not know whether you can deal with the workforce issues, Steve.

11.30 a.m.

[174] **Mr Elliot:** The reason for the transfers out of the workforce budgets is mainly because, historically, they held the pay modernisation budgets. Now that we have put that into the allocation, that has gone out. Again, that was something that we went through in the in-year transfers. It is just making that adjustment recurrent. There have not been any changes to the level of the workforce budget itself.

[175] **Jenny Randerson:** I would like to ask a separate question but, before doing so, I express my deep concern that the Assembly Government has been put in this financial position by the Treasury. I understand—as we all do—that it is a UK-wide problem, but when there is such a problem we normally get reallocations. We get supplementary money through all the time. I think that this is unacceptable: £17 million may be nothing to Gordon Brown but it is a great deal to our Minister and our health service.

[176] I have a question on something different, which relates to primary care. That budget has gone down by £5.6 million on the original plan. You say that that is due to the transfer out of the dental contract but in paragraph 17 of your report you refer to £1.1 million. Therefore, there appears to be a gap, unless I am misunderstanding it. Can you say how much has been transferred to the dental contract precisely?

[177] **Brian Gibbons:** Again, I think that I will have to ask Steve to answer that.

[178] **Mr Elliot:** I am afraid that I cannot give a precise figure, without going through it. What we have provided for in dental contracts is funding it at this year's level and to what we anticipate to be the growth needed for 2007-08. We will give a more detailed answer in writing, if that is all right—

[179] **Jenny Randerson:** We would value a precise answer on that. Further to that, there is concern, on this side, that the primary care budget appears to be under pressure at a time when you are looking to primary care to do so much more, with 'Designed for Life' and so forth. I know that there are all sorts of strands of money going into primary care and that this is only one part of it. My attention has been drawn this morning to the pressures on Citizen's Advice and its Better Advice, Better Health scheme. It seems that we have a burgeoning role for primary care and that, therefore, this budget really needs to recognise the all-encompassing vision that you have for it, Minister.

[180] **Brian Gibbons:** I am not so sure. I agree that when you look at these tables and you see primary care—equally, if you were to try to find cancer or respiratory disease in these things—it is very difficult and it would certainly be incorrect to say that this reflects the situation. The general medical services contract, as we know, has a substantial increase in it. Most of the prescribing budget is in primary care and it is had a 7 per cent uplift. All over this, there are substantial shifts going into primary care. The DESes, LESes and the RESes and all those are all going on. I understand that, philosophically, it would be inconsistent for us to be talking about primary care and then taking the money away from it. However, I do not think that trying to analyse it through this budget is an accurate way of getting to the bottom of the investment that is going in there.

[181] **Rhodri Glyn Thomas:** Diolch yn fawr i'r Gweinidog, ac i Steve Elliot am ei sylwadau. Ar ran y pwyllgor, hoffwn ddiolch i wasanaeth ymchwil yr Aelodau yn benodol am y gwaith a wnaed, nid yn unig ar y gwaith papur ond hefyd ar y sesiwn briffio a gawsom, a oedd yn ddefnyddiol iawn. Mae wedi caniatáu inni fod yn benodol yn ein sylwadau a'n cwestiynau ar y gyllideb.

Rhodri Glyn Thomas: Thank you, Minister, and to Steve Elliot for his comments. On behalf of the committee, I thank the Members' research service specifically for the work that it has undertaken, not only with the paperwork but also with the briefing session that we received, which was very useful. It allowed us to be specific in our comments and questions on the budget.

11.34 a.m.

Adolygiad y Pwyllgor o Wasanaethau Canser
Committee Review of Cancer Services

[182] **Rhodri Glyn Thomas:** Yr ydym yn gwahodd at y bwrdd Viv Cooper, sef cyfarwyddwr clinigol Tŷ George Thomas, a oedd cyn hynny yn rheolydd ar wasanaeth gofal canser Marie Curie ym Mhenarth. Hefyd mae gennym Karen Wright, prif weithredwraig Claire House, a Muriel Barber, rheolydd gofal Claire House. Deallaf fod Muriel yn symud ymlaen yn fuan, ac yn gadael ei swydd yn Claire House. Fel un sydd wedi bod yn Claire House—gwn bod aelodau eraill o'r pwyllgor wedi bod yno hefyd—mae'n briodol ein bod yn cydnabod y gwaith y mae Muriel wedi'i wneud. Mae hi wedi bod yno o'r cychwyn, ac, yn wir, ychydig cyn i'r adeiladu ddechrau ar Claire House, ac mae hi wedi arolygu y gwaith a wnaethpwyd. Felly, hoffwn gydnabod y gwasanaeth gwerthfawr y mae hi wedi ei roi, a rhoi ein dymuniadau gorau iddi hi i'r dyfodol.

Rhodri Glyn Thomas: We invite to the table Viv Cooper, the clinical director of George Thomas Hospice, and previously manager of the Marie Curie cancer care service in Penarth. Also, we have Karen Wright, chief executive of Claire House, and Muriel Barber, care manager at Claire House. I understand that Muriel will be moving on soon and leaving her job at Claire House. As one who has visited Claire House—I know that other committee members have also visited there—it is appropriate that we acknowledge the work that Muriel has done. She has been there from the beginning, and, indeed, before the beginning of the building of Claire House, and she has overseen the work that has been done. Therefore, I would like to acknowledge the valuable service that she has provided, and give her our best wishes for the future.

[183] Mae papurau wedi eu cyflwyno, a dechreuwn â phapur Viv Cooper. Felly, gofynnaf i chi wneud sylwadau neu ofyn cwestiynau yn benodol ar hwnnw. Mae croeso i Karen a Muriel ymuno yn y drafodaeth, os dymunant. Mae Andy Fowell yma i gynrychioli'r grŵp cyfeirio arbenigol.

Papers have been presented, and we will start with Viv Cooper's paper. Therefore, I ask you to make comments or ask questions specifically on that. Karen and Muriel are also welcome to join in the discussion, if they so wish. Andy Fowell is here to represent the expert reference group.

[184] **Jonathan Morgan:** First, I would like to say how grateful I am for the reports. It is very good to see you all again. I know that we all value the tremendous role of the hospice movement in Wales and several of the issues that you alluded to in your reports will certainly help us in our deliberations, because there are challenges that we have to get to grips with.

[185] Viv, in your report, you said that 27 per cent of deaths during 2003 related to cancer. You went on to say that 56 per cent of people would prefer to die at home, but that only 20 per cent do, and that 24 per cent would prefer to die in a hospice, but only 4 per cent do. I would like some clarification on that. In relation to the 56 per cent who would prefer to die at home, is that 56 per cent of the 27 per cent, or is it 56 per cent of those people who—

[186] **Ms Cooper:** It is 56 per cent of a well population. That comes from part of the campaign that, I think, I came to talk to you about. Getting proper statistics from people who are dying about where they would like to be at the end of their lives, is work that we are involved in at the moment. However, that work has only started in the last couple of years, so we are collecting hard data about that, but we do not have it today.

[187] **Jonathan Morgan:** A lot of good work is done by the hospice movement and the

voluntary sector in general in funding posts within the NHS. Very often, without that funding, those posts would have to be funded by the NHS, and it may struggle to resource that. How many posts are funded by the hospice movement and the voluntary sector in Wales compared, perhaps, with other parts of the UK?

[188] **Ms Cooper:** It is difficult for me to quantify how many posts are funded throughout Wales; I am sure that Andy could comment on that. I could talk about the local context. In Cardiff and the Vale, for example, there are two hospice providers that spend around £3 million a year, to keep patients in hospices and at home, on medical staff, on nursing staff, occupational therapy, and the full multidisciplinary team. Very few of the posts in Cardiff and the Vale, even the hospital-based posts, are funded by the NHS, and, if they are, they started out with funding by Macmillan.

[189] **Rhodri Glyn Thomas:** On that point, Andy, do you have the national figures?

[190] **Dr Fowell:** I do not, but the Minister has asked for a mapping exercise to be done, and I believe that the tender has been accepted last week. I assume that work will be going on over the next few months to try to quantify an answer to that question.

[191] **Jonathan Morgan:** I asked the question, Chair, because if a mapping exercise is to be done, which is terrific, I think that it should be able to inform the outcome of this review. I would like us to be able to quantify, as far as we are able, the contribution of the hospice movement and the voluntary sector in general in Wales to the provision of cancer services and the support that is made available, because it is substantial. Often, it goes unrecognised. I know that we do what we can to recognise it, but we should be putting a great deal of effort into explaining in our report the value and the contribution that is made. I do not know how quickly that exercise will be undertaken, but the quicker the better, so that it can inform this report.

11.40 a.m.

[192] I have two other quick points, Viv. You made reference to the strategic document that the Government published in 2003 on palliative care, and that local health boards and networks should work positively with the sector to ensure that funding issues are placed on a sound footing. You then went on to talk about the grant that was made over the three-year period, the £10 million, which was there to improve capacity and to provide for improvements. However, my understanding is that, at the end of that funding period, the local health boards will be responsible for commissioning any services that were made available when that £10 million was being spent. Have you had any indication from the local health boards that they will take up the commissioning of any of the projects that were supported by that £10 million? Maybe that question could also be answered by the witnesses from Claire House. I think that there is a real concern about the fact that money was made available but that there is a question of how sustainable it is beyond the funding period.

[193] **Ms Cooper:** At the outset, our expectation was that if we developed services that were well evaluated and that showed a real benefit to patients and their families, the funding would be taken up. The indications are, and my experience is—and it was said by several LHBs during the commissioning and contracting meetings—that it will not be taken up.

[194] **Jonathan Morgan:** As a quick supplementary, have reasons been given as to why several LHBs have decided not to pursue those projects? We did welcome the £10 million that was allocated, but my concern is that, if projects and commissioning services are not being taken up by LHBs, people will ask what was the point of putting in money in the first place if it is unsustainable. I would be rather concerned if local health boards were not following up the good work that was achieved with that money.

[195] **Ms Cooper:** I can give the example of a project that I have been involved in running. There is no question about its value, but there is no extra money to continue to run that service. That has been the response. It is a core service; it is not new or any different from what lots of other hospices are providing. It is a hospice at home, essentially—a crisis hospice-at-home team.

[196] **Rhodri Glyn Thomas:** I will bring Karen in, because her situation is different. She works with local health boards here and with the system in England as well.

[197] **Ms Wright:** Yes, but our experience in England was that we had a hospice-to-home service that cost only £64,000 a year, and that was evaluated as being very well received by the people who used it. The service was part-funded by the lottery, and one of the reasons that we got lottery funding was because we worked with the primary care trust and another voluntary agency, and the exit strategy was that the primary care trust would pick up that funding. However, the PCT did not pick up that funding, as it had no money. Part of the issue was also that that service was so well valued, so we have continued it by having an appeal, a sponsor-a-nurse campaign. Part of it is that, to a certain extent, we do not get funding from the Government. Well, we have just got statutory funding, but it has been reduced by 10 per cent, because 10 per cent of our services go to children in Wales and the funding is only for children in England. Again, that is just for three years, and it is only 10 per cent of our funding. The local PCTs know that we will not stop doing things as long as we can raise the money, so, to a certain extent, we are in a catch-22 situation. The hospices that are setting up are doing things differently, but, because we provide our services for free, we will not stop providing them. We are in a no-bargaining position, really. The local PCTs rely on our services, but they know that they do not have to pay for it.

[198] **Jenny Randerson:** You mentioned just now that you are getting statutory funding in England. Does that relate to the reference in Viv's paper that, in England, the core costs are now being met?

[199] **Ms Wright:** No, that is not the case. The Association of Children's Hospices campaigned for the Government in England to replace the lottery funding, because that ended and it was supposed to be picked up by PCTs. The Government put £27 million into the Department of Health over the next three years for hospices, which is £9 million a year, and that worked out as about £200,000 per hospice. That is the only statutory funding that we have got.

[200] The interesting thing from our experience of that is that the Government said that the funding was for core services that we were already running, but actually, when it came down to the civil servants getting that money, all they did was use a section 64 grant form and change the wording on it, and it was still a project-based form. So, we still had to leap through all those hoops of providing all this information twice, and at very short notice. I think that they told us on 5 September that we had to go through a second process by 11 September. So, there is a lot of work involved to get the moneys, and it is still only for three years, we still have to reapply every year, and it still covers only a very small portion of our costs.

[201] **Jenny Randerson:** I have a real concern about the complexity of the negotiations, the lack of service level agreements, and the fact that hospices and palliative-care providers generally in Wales have to negotiate with lots of LHBs and so on.

[202] I also have a concern about the fact that rural areas get a very poor level of service, simply because they do not generally have hospices there. Is the message in your papers that you would welcome service level agreements and some kind of co-ordinated approach to discussions with LHBs? Do you think that a proper strategy for palliative care would

contribute positively to a more coherent and efficient approach? One thing that concerns me is that if LHBs are not picking up the gap as the £10 million runs out, people will be either dying at home, served and funded by district nurses and paid for by the NHS, or dying in hospital, paid for by the NHS. It strikes me that a very short-sighted approach has been taken to the positive contribution that the hospice movement makes.

[203] **Ms Cooper:** We would certainly welcome more secure agreements. We have service level agreements, but they are always for one year, and are often for one year with a review. So, we are reviewed, usually annually, and we do not mind that. We are providing quality information and everything that is needed to show the value of our services, but it is not really a commissioning arrangement; it is a contract, which can often arrive through the post for a signature. That means that there has been no dialogue and no partnership, so there is no security.

[204] As voluntary providers, we are all planning services with NHS partners, and some unique service development is going on. So, we are not standing still, but we have absolutely no security apart from the year-on-year contract. There may be a conversation or it may just arrive through the post for a signature. Doing that 22 times throughout Wales, as I did in my previous job, is not a good use of a clinical person's time.

[205] **Dr Fowell:** Jenny raised the issue of the strategy on palliative care in Wales, which was published in 2003. The headline messages of that were about equity of access, recognising that there is a rural hinterland to Wales, and also about putting the voluntary sector on a firm financial footing. Those were the two main messages that came out of that. So, it is not as though this issue has not been discussed or no attempts made to move it forward; we have just not got to that level. The other thing that the strategy talked about was the integration of services.

[206] **Rhodri Glyn Thomas:** Jenny, did you have anything further to add?

[207] **Jenny Randerson:** No, that is fine.

[208] **Rhodri Glyn Thomas:** Helen, you wanted to comment.

[209] **Helen Mary Jones:** My questions are really to both of you, and I thank you both for your papers and the evidence on paper that will be very useful for us for the review.

11.50 a.m.

[210] One thing that LHBs sometimes put to me when I raise these kinds of issues with them is the perceived difficulty of sorting things out. That is, the difficulty in having arrangements with hospices, and in sorting out the core medical care that patients would otherwise receive from a district nurse at home or, more often, in an acute ward in hospital if they are in an in-patient bed in a hospice. One manager, whose wrist I slapped for saying this, described the extra bits that cover everything from aromatherapy to having nicer curtains as 'the bells and whistles'. How easy would it be for you to say, 'Right, Claire House takes three kids from Gwynedd every year; this is the element of their care that is extra, that is, the add-ons that we can legitimately expect the voluntary sector to fund from voluntary contributions, and this is the medical and social care that would otherwise be provided to that child and that family'? If you could do that, there would be a stronger case.

[211] The other thing that LHBs say—and I have to say that, when I quote them, I do not necessarily agree with them—particularly when it comes to children's services, and more specialised hospice or other voluntary services, is that because each hospice or provider is unique and individual, they have the same kind of trouble, because each hospice or voluntary

organisation wants to deal with them differently. We would all think that the idea of clinical people having to negotiate 22 contracts for national services is completely barmy and a very bad waste of everybody's time. However, they see it from the other end. Do you have any comments about the extent to which the hospice movement co-operates and competes with other voluntary sector palliative-care providers in the community, such as Marie Curie, among others? If we are to reach some conclusions about our possible recommendations to the Minister, Chair, there may also be things that we will ask the voluntary sector to do differently. It is fairly clear that there will be things around commissioning that we will be asking the statutory sector to do differently. If there is more co-operation and if you were all singing from the same hymn sheet, perhaps it would be easier for us to make the case.

[212] So, there are two points: how easy is it to identify the core service, namely those things that would have to be provided elsewhere; and are there ways in which you could co-operate more effectively, or to what extent do you already co-operate? Is it also fair to say that you do not co-operate enough?

[213] **Ms Cooper:** I can speak only for adult services, obviously.

[214] A lot of work is being done on the definition of core services. Work is being done by the National Hospice Council on a formula for the cost of a bed day or the cost of a visit by a specialist nurse. That work is already done, and is being developed. That has not been easy, and, historically, competition was probably a good argument. How much are we really competing? The fundraisers are always competing, and that is their job, but, as clinicians, over the past five years, we have been meeting and talking to each other. It does not matter which badge you wear because—taking Cardiff and the Vale as the example again, as that is where I have been working—it is about which organisation can best serve a patient and his or her family, or which parts of various organisations can come together to best serve their needs. I do not think that we are duplicating or competing at all for patients or for work. The fundraisers are definitely competing, and that is their job.

[215] **Ms Wright:** Operationally, no, we do not compete. We are full, and we take children based on their need.

[216] Where Governments get stuck is when, for example, we apply for lottery funding, because the amount of paperwork that we had to complete for £324,000, on a bid for up to £2 million, meant a lot of work for something that in no way covered the cost of the services. It is like having two different cultures. We could easily pick out the medical services that we are providing and say that they cost £15, but I would not care if I got only £5, because I am not getting anything at the moment. There seems to be a mindset in the health boards funding PCTs that they have to fund the whole cost of that medical cover. We can easily provide the statistics of what is medical cover and what is social cover.

[217] The difficulty in caring for children with complex needs is that one day it might be 80 per cent social care and 20 per cent medical care. If they are very poorly, it might be 90 per cent medical care and 10 per cent social care. We run a bespoke service—it is not a one-size-fits-all service—and because we do not tick just one box and the funding pots tend to be rigid, it is sometimes difficult to be flexible. Children and families who use our services can be in control, and we can be flexible. Since we depend completely on fund-raising, I would not want to lose that independence. The hospices are asking for some type of safety net, so that you could guarantee that 20 to 30 per cent of the funding was coming through. That would give my fundraisers only 70 per cent to raise, so it would give them something that they knew was there on a statutory basis. The hospices are grateful for the lottery money, but in no way did it cover the whole cost of the services—it was probably around 8 per cent to 10 per cent.

[218] **Ms Barber:** I want to talk about the clinical needs and the needs of the children and

families. One of the important things that I have learnt in the time that I have been at Claire House is about partnership working. Whoever you work with, you must look at the needs of the child or the family, and it is equally important that hospices such as Claire House educate and train staff to provide a good service. For instance, our outreach service went out to a 16-year-old girl to nurse her through end-of-life care. I am not knocking district nursing services, but we do not have such services that are able to provide the level of expertise in caring for a 16-year-old in the community, so you must ask what services are being provided in the community.

[219] In Merseyside and Cheshire, in terms of the cancer network group as regards children's services, we have pushed ourselves forward and said that the children's services are here. In Claire House, there is also a gap in terms of those between the ages of 18 and 23 and where they go, and that is something that we have identified. However, it is about partnership working and care pathways. We have taken a look at the Liverpool care pathway for the dying, which is important, and it is about focusing on need.

[220] **Rhodri Glyn Thomas:** I know that we have already strayed into the papers produced by Claire House, but can we turn to those papers now in terms of the other issues?

[221] **Helen Mary Jones:** My question builds on an issue that Muriel highlighted about transition. Can you tell us a bit more about that? The current situation is pretty stark, and I know that we talked about it when I came to visit you. What needs to happen to change that? I know that it is a huge question, but are there specific things that we need to say in our recommendations, namely that certain things need to be put in place to develop the type of pathways that you are talking about? The transition from children's services to adult services is difficult in many ways, but when you are talking about a young person who may die during that period, it is even more important to get it right.

[222] **Ms Barber:** I can only speak from the experience that we have had in Claire House. On this occasion, I hold my hands up and say that education and social services are probably better than health services. I think that they identify very early on what we need to be planning ahead for and what will be in the best interests of those young people in the future. We have drawn up a transitional care policy within Claire House, because we recognise that the path ahead will be bumpy. All of a sudden, people will realise that Claire House will take young people up to the age of 23, but what will happen to these youngsters when they get to the age of 23? So, within health, I feel that education and social services are better at transition in terms of looking at children from a very early age—as early as 14 years of age. Thinking about the need and providing the appropriate environment for people is equally important, but people need to work together. Some of our children and young people are quite lost—and I am not knocking adult services in any form—because they have had this motherly, nurtured care in paediatrics, and then they go to adult services, which is extremely different. So, this idea of combined clinics and having an adult physician and paediatrician will be helpful. That should probably also happen in health and education.

12.00 p.m.

[223] **Ms Wright:** The only way of getting things done is to model it, and we are working with two local adult hospices in that regard. We developed a teenage annex to take young people up to the age of 23. There is no reason why the local adult hospice could not have developed a young people's annex, but I think that it is about not knowing how such an annex would fit in with the services offered at adult hospices given that adult hospices offer very different services from those of children's hospices. Sometimes, I think that the voluntary organisations could raise the money to set up an innovative service and show that it can be done. They could model such a service, whereas, often, statutory agencies do not have the provision in their budgets to model a service that does not fit into a certain box.

[224] **Jenny Randerson:** A reference in Viv's paper also applies to you. Viv's paper says that the average NHS contribution to hospices in England is 45 per cent, but that it is only 21 per cent in Wales. Those are very stark figures.

[225] **Ms Wright:** Those figures are for adult hospices.

[226] **Jenny Randerson:** However, children's hospices only get 4 per cent of NHS funding.

[227] **Ms Wright:** That is an average; some get nothing.

[228] **Jenny Randerson:** Have you been able to detect why, for some extraordinary reason, the NHS recognises the significance and the needs of dying children less than it recognises the needs of dying adults?

[229] **Ms Wright:** My feeling is that that is probably because the service that adult hospices provide is different to that provided in children's hospices. Sometimes, the word 'hospice', when applied to children's hospices, is the wrong word because adults going into adult hospices normally have a clinical need. It is easier to see what their medical needs are, whereas, with children, we often deal with complex needs and some of the care that we offer is respite care for families because we care for the child while the parents go on holiday. That is social care, but in a medical setting. That is why it is much harder to define. Often, with parents of very sick children, their energy is so involved in the care of that sick child that they do not have the energy to battle for funding, whereas the families of adult hospice users have the energy, and they also vote, whereas children do not.

[230] **Rhodri Glyn Thomas:** Andy, do you have any issues that you wish to raise with Viv, Karen or Muriel?

[231] **Dr Fowell:** No, I think that we have covered much of what we discussed. Claire House mentioned the Liverpool care pathway and I would like to confirm and flag up the fact that we have had a project running in Wales, for around five years, on implementing the care pathway for the dying throughout Wales. That has been very successful and we have looked after over 5,000 patients. Around 1,500 patients every year are being cared for through that pathway. So, that project is ongoing.

[232] On the funding for hospices, I feel that we could consider a way forward here. There is scope for using existing mechanisms. To my mind, it is slightly strange that a hospice, which is caring for a patient—who is, therefore, saving the NHS money by not being in a hospital or a nursing home bed—cannot claim continuing care funding for that patient. That seems slightly strange. If they were able to claim that funding, they would have a secure income stream that would be slightly more than what they currently get, on average. So, there is perhaps a mechanism there for in-patient hospices. However, it becomes slightly more complicated when you look at day hospices and home care; it is rather more difficult to see an easy way forward in those terms.

[233] **Helen Mary Jones:** I have a difficult question for the three of you. If there were one thing that you could ask the committee to recommend in its report to the Minister—of all the things that need to be done, the one thing that would help to crack it for you in terms of a priority—would you be able to identify that one thing that you needed us to ask the Minister to do?

[234] **Rhodri Glyn Thomas:** Apart from fully funding your services.

[235] **Helen Mary Jones:** Yes, apart from that, which we might or might not ask him to do.

[236] **Ms Cooper:** One thing for the adult services that I am involved in is security of funding. Clearly, we would like more funding, but we would like some security so that we know that we can develop our services going forward.

[237] **Ms Wright:** For the children's hospice, it would be to ask, not only to be fully funded, but for some recognition that the Minister thinks that what we are doing is good. However small that recognition is, financial recognition always shows that, from a Government's point of view, it thinks that you are doing a good job.

[238] **Rhodri Glyn Thomas:** Muriel, would you like to comment from the care point of view?

[239] **Ms Barber:** I think that we have a lot to sell to statutory services. What we provide in hospices is excellent, but it is about working together. That is important. The road ahead is going to be difficult for anybody when it comes to funding and so on, but people have to recognise just what we provide in hospice care.

[240] **Rhodri Glyn Thomas:** Okay. Is there anything else that any of you want to add? We have looked at the papers that you have produced and they will be incorporated into the body of evidence that we have and will play a full part in the recommendations that we will be developing. Is there anything that you want to add orally?

[241] **Ms Wright:** For me, one of the positives is that the National Assembly is doing a review of cancer and palliative care services, because it shows that there is a commitment to look at what works and what does not work and to provide services that meet the needs of children and families. You are listening to people like us, which is positive.

[242] **Rhodri Glyn Thomas:** Thank you for the work that you did in producing those papers, which were very good, and for coming along and giving evidence today. It has been useful in terms of collecting the hands-on evidence that we need to prepare our report.

[243] Y cyfan sydd yn weddill o ran y pwyllgor yw nodi'r pum papur. Diolch yn fawr i chi gyd.

All that is left for the committee is to note the five papers. Thank you all very much.

Daeth y cyfarfod i ben am 12.07 p.m.
The meeting ended at 12.07 p.m.