Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

The National Assembly for Wales
The Health and Social Services Committee

Dydd Iau, 30 Tachwedd 2006
Thursday, 30 November 2006

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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, Ann Jones, Helen Mary Jones, Jonathan Morgan, Jenny Randerson.

Swyddogion yn bresennol: Ginny Blakey, Swyddfa'r Prif Swyddog Meddygol; Dr Tony Jewell, Carloyn Eiason, Gwasanaeth Ymchwil yr Aelodau; Prif Swyddog Meddygol; Amanda Jones, Tîm Gofal Cymdeithasol; Peter Jones, Cwnsler Gwasanaeth Seneddol y Cynulliad; Ann Lloyd, Pennaeth, Adran Iechyd a Gofal Cymdeithasol; Liz Lockwood, Y Gangen Polisi Pobl Hyn a Gofal Hirdymor; Stuart Moncur, Adran Iechyd a Gwasanaethau Cymdeithasol; Mark Partridge, Cyfarwyddwr Cynorthwyol Gwasanaethau Cyfreithiol; Kathryn Potter, Gwasanaeth Ymchwil yr Aelodau; Rachel Stephens, Tîm Gofal Cymdeithasol.

Gwasanaeth Pwyllgor: Jane Westlake, Clerc; Sara Mansour, Dirprwy Glerc.

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

Officials in attendance: Ginny Blakey, Office of the Chief Medical Officer; Carolyn Eiason, Members' Research Service; Dr Tony Jewell, Chief Medical Officer; Peter Jones, Counsel to the Assembly Parliamentary Service; Ann Lloyd, Head, Health and Social Care Department; Liz Lockwood, Older People and Long-term Care of the Elderly Policy Branch; Stuart Moncur, Health and Social Services Department; Mark Partridge, Assistant Director Legal Services; Kathryn Potter, Members' Research Service; Rachel Stephens, Social Care Team.

Committee Service: Jane Westlake, Clerk; Sara Mansour, Deputy Clerk.

Dechreuodd y cyfarfod am 9.31 a.m.
The meeting began at 9.31 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. Hoffwn fod y cyntaf i longyfarch Jonathan Morgan ar gael ei ddyfarnu fel yr Aelod Cynulliad gorau neu fwyaf addawol neu gynhyrchiol yn ystod y flwyddyn ddiwethaf yn y cinio neithiwr. Mae'n amlwg fy mod wedi bod yn llawer rhy garedig iddo yn ystod y flwyddyn ddiwethaf, felly, caiff ei alw'n olaf ar bob eitem ar yr agenda yn ystod y cyfarfod pwyllgor hwn heddiw. [*Chwerthin.*]

Rhodri Glyn Thomas: Good morning and welcome to the meeting. I would like to be the first to congratulate Jonathan Morgan on being named the best or most promising or productive Assembly Member of the year at yesterday evening's dinner. I must have been much too kind to him in the past year, therefore, he will be called last on every item on the agenda during this committee meeting. [*Laughter.*]

[2] **Jonathan Morgan:** Thank you, Chair.

[3] **Rhodri Glyn Thomas:** Hoffwn groesawu pawb yn oriel y cyhoedd, a gwnaf y cyhoeddiadau arferol. Os oes gennych unrhyw fath o offer electronig, a wnewch chi eu diffodd, os gwelwch yn dda? Nid yw'n ddigonol eu bod ar 'distaw' gan fod hynny'n

Rhodri Glyn Thomas: I also welcome everyone in the public gallery, and make the usual announcements. If you have any kind of electronic equipment, please switch it off. It is not sufficient to put it on 'silent' because it will affect the recording

effeithio ar ein hoffer recordio. Mae'r offer cyfieithu hefyd yn gallu eich cynorthwyo i glywed siaradwyr, yn ogystal â darparu'r cyfieithiad.

equipment. The translation equipment will also assist you in hearing speakers, as well as providing the translation.

[4] A oes unrhyw ddatganiadau o fuddiant? Gwelaf nad oes. Yr ydym wedi derbyn ymddiheuriad oddi wrth Karen Sinclair, sy'n methu â bod yma heddiw. Mae Lynne Neagle hefyd yn ymddiheuro.

Are there any declarations of interest? I see that there are none. We have received apologies from Karen Sinclair, who cannot join us this morning. Lynne Neagle has also sent her apologies for absence.

9.33 a.m.

Adroddiad y Gweinidog
Minister's Report

[5] **Rhodri Glyn Thomas:** Cymeraf eich cwestiynau ar eitemau 1 i 4 yn adroddiad y Gweinidog.

Rhodri Glyn Thomas: I will take your questions on items 1 to 4 on the Minister's report.

[6] **Helen Mary Jones:** I just wanted to comment on the Bryn-y-Neuadd resettlement programme. I think that we all understand how complex the issues can be, particularly when it comes to meeting individual choice. However, I express a concern about the slippage in the timescale. I am just seeking the Minister's reassurance, as far as possible, that we are not anticipating a further slippage. It is incredibly difficult to move out people who have, perhaps, spent most of their life, not just their adult life, in these institutions. I completely respect what the Minister's report states about the need to ensure personal choice, but I would just hope that we are not anticipating the timescale slipping any further.

[7] **The Minister for Health and Social Services (Brian Gibbons):** On this, the money is in the budget. I think that it may be a fairly explicit line. I do not know.

[8] **Ms Lloyd:** Yes, it is.

[9] **Brian Gibbons:** Therefore, I think that the resources are there. It is just a case of some bureaucratic steps such as planning and making sure that the residents are happy with what is proposed for them, and so forth. You have to go through the process. The money is there. We would be anxious, but not rushing people into it for the very reason that I have just said. It is very difficult and has to be done sensitively without doubt.

[10] **Rhodri Glyn Thomas:** Jenny Randerson, ar eitem 4?

Rhodri Glyn Thomas: Jenny Randerson, on item 4?

[11] **Jenny Randerson:** I very much welcome the Minister's decision on the statutory health professional advisory committees. I think that it is a very wise decision.

[12] **Rhodri Glyn Thomas:** Yn olaf, Jonathan Morgan.

Rhodri Glyn Thomas: Lastly, Jonathan Morgan.

[13] **Jonathan Morgan:** I endorse what Jenny has said. It is a sound decision and it was clearly based on evidence. That is obviously the best way of proceeding.

[14] On point 3, you said that there is not a lack of Assembly resourcing. What was the original assessment of how much the project was going to cost? How much has been spent? I

echo the concerns that Helen Mary raised about the fact that this needs to be completed as quickly as possible. We accept that there is likely to be slippage with a project of this nature but the more that can be done to get this completed as quickly as possible, the better.

[15] **Brian Gibbons:** Ann has just said that something in the order of £8 million is going in to do that but, if you want, we can get the details of what the spend has been up to now and what is projected.

[16] **Rhodri Glyn Thomas:** A oes unrhyw beth ar eitemau 5 i 8?	**Rhodri Glyn Thomas:** Is there anything on items 5 to 8?

[17] **Jenny Randerson:** On item 5 and the levels of funding, I fully endorse the concept of Health Challenge Wales and getting people to be more active but, forgive me for being a little cynical about this. The report states:

[18] 'Sustrans Cymru: Active Travel Programme for Wales aims to increase physical activity by making it easier to choose sustainable/active ways of travelling.'

[19] The way to do that is to ensure that you have cycle lanes in place. Are you paying for the cycle lanes or railway stations? I would be slightly worried, to say the least, if the health budget was being diverted into the transport programme, even though I fully understand the links between the two. I would be interested to know what kinds of levels of funding we are talking about in terms of all three of these. The green gym network is a totally different issue.

[20] On item 6, does this service development mean that we are going to have reablement activities? People talk to me about the lack of gymnastic-based reablement activities in clinics in some parts of Wales. Just getting people active again is not possible because the clinics do not exist. So, does it mean that those will exist throughout Wales?

[21] On multiple sclerosis, you will be aware that the fiftieth anniversary of the Multiple Sclerosis Society was this week, Minister, and John spoke as Deputy Minister there, and we are all very grateful for what it does. However the chair told us that there are still problems with getting this money through. Where is this £700,000 and has any of it yet been spent? Why does the society regard there still to be problems?

[22] There is an issue about future funding. Is this a one-off thing or are you going to put in a much bigger and more sustainable amount of money for the future? I thought that the review that you referred to in point 7.3 was under way. I have asked you written questions about this and you have replied but that was some time ago and I am disappointed to hear that the review is not under way. Despite your replies, I do not see why we are doing a separate review in Wales that appears to be wider than the review in England. How do the two fit together?

9.40 a.m.

[23] **Rhodri Glyn Thomas: A**tegaf y pwynt y mae Jenny Randerson wedi ei wneud. Yn sicr ar bwynt 7, ar sglerosis ymledol, gobeithiaf y bydd y Gweinidog yn cydnabod y rôl y mae ffisiotherapi—	**Rhodri Glyn Thomas:** I support the point that Jenny Randerson raised. Certainly on point 7, on multiple sclerosis, I hope that the Minister will acknowledge the role that physiotherapy—

[24] **Brian Gibbons:** Sorry, Chair, but my translation headset is not working.

[25] **Rhodri Glyn Thomas:** I will repeat. I hope that you, as a Minister, are going to acknowledge the role that physiotherapy plays in treating people with multiple sclerosis. In

terms of respite care, which is a tremendous problem in Carmarthenshire as Helen Mary will confirm, will you, Minister, try to ensure that there is sufficient capacity in respite care to ensure that carers have that kind of reassurance?

[26] **Brian Gibbons:** The activity scheme is basically to facilitate uptake. In other words, it is to encourage activities, more than it is to provide the physical amenities per se. It is basically using Sustrans, the British Trust for Conservation Volunteers and Living Streets to facilitate promotional activity, rather than providing physical facilities in general. It is part of a bigger scheme that runs to about £0.5 million. For example, members of the BTCV's Green Gym network go out to areas and try to redesign certain parts of the natural environment so that people can go out and use it in a controlled way, and display the Green Gym logo or branding, or whatever you want to call it. I have seen Living Streets in operation in Cathays park, for example; people have been trying to organise walks around Cardiff at lunchtime as a part of Health Challenge Wales. They have also been trying to encourage people to get out and about during lunchtime, instead of sitting around engaging in sedentary activity. Living Streets is part of that and, equally, Sustrans is doing the same thing, particularly involving cycling and so on; it is encouraging people to participate rather than providing bikes or cycle lanes. Some of these things are soft programmes and that is why I think that the evaluation is important. It is a lot of money at the end of the day, and we want to ensure that it is delivering a dividend. That is why the evaluation is a key part of it. Even though it is all very nice and cuddly and so on, if it does not deliver outcomes, we have to look at what that money should be spent on.

[27] The idea behind the respiratory commissioning directives and so on is that there will be a Wales-wide network. There is no doubt that graded physical activity makes a big difference. I was down at the velodrome in Newport and saw this graded physical activity. It seems fairly obvious that a lot of people with lung disease get physically unfit, as they are unable to walk very much and their muscles get wasted because of a lack of use. Building up your muscles gradually leads to overall reablement and I think that that sort of physical reablement programme should be part of the overall programme. The whole point of doing it this way is so that there is a consistent pattern of service delivery across Wales. This is part of our wider chronic disease management programme and there should be consistent patterns across Wales, regardless of where you are.

[28] With regard to the disease-modifying drugs for multiple sclerosis, on the present basis, we would hope that this money will continue as long as the risk-sharing scheme is there. The work that Health Commission Wales is proposing—I do not know whether Ann can tell us how far advanced it is—will mainly look at how the guidelines on the use of the drugs are being used here in Wales. In other words, it will look at whether the starting criteria, the stopping criteria and so on are being properly adhered to. At one stage, our view was that there was reasonable consistency in starting the drugs, but many people were continuing to take them and there was no stopping criterion, or the stopping criterion had not been implemented. So the HCW is looking at that element of how the scheme works. However, at this stage, it seems as though sufficient people have already been recruited into the risk-sharing scheme even before the end of the decade to start to make some clinical evaluations as to how effective the treatment is.

[29] We have this risk-sharing scheme because the initial National Institute for Health and Clinical Excellence assessment stated that these drugs were pretty marginal, and only through the risk-sharing scheme was it possible to run a cost-effective programme. Enough patients now seem to be enrolled on the programme to start coming to some conclusions. Our understanding is that, by the middle of next year perhaps, some preliminary results will come through. If that vindicates the effectiveness of the treatment, that would be good, because people will obviously benefit from it. However, if the evidence is no more resilient now than it was then, or if it is even less resilient, we must make evidence-based decisions in those

areas. However, until we see the evidence, I do not think that we can say any more. Ann or Tony, do you want to add something to that?

[30] **Ms Lloyd:** Yes. As part of the guidance from NICE, you have to look at the criteria being used to ensure that there is absolute equity, and that the same criteria are applied throughout Wales in the three treatment centres. We have already assessed the needs and have found that they are higher than originally assessed when the scheme was set up, so additional resources have been provided. However, if people meet the criteria, there should be no delay in their entering into the scheme just because we are checking whether or not there is consistency. It is important to have that consistency, as we cannot have inequity.

[31] **Rhodri Glyn Thomas:** What about the points that I raised about physiotherapy, occupational therapy and respite?

[32] **Brian Gibbons:** In general terms, I hope that those will be included in the commissioning document on epilepsy and other neurological services. The same chronic disease model will apply to multiple sclerosis and so forth. However, I have not seen a draft of the epilepsy and neurological condition document, so I do not know the precise detail of it. Epilepsy was chosen because it is a common condition and, as such, is a useful template for neurological conditions. Similarly, because other neurological conditions would be covered in that document, that general systematic process, which is in the respiratory document, would be carried over into the document on neurological conditions. However, as I have not seen a draft of it, I cannot give you the precise details of its content, but what you say seems to be self-evident. Tony, do you want to say something on that?

[33] **Dr Jewell:** The Minister is right; we have not yet received that document. We have a copy of the respiratory document, and it is out to consultation, but it is not for those other conditions. The disease-modifying drugs are essentially the high cost drugs for MS, which was the particular issue and that is why we are looking at this now. However, the neurological conditions and epilepsy have not yet been worked up into a consultation document, but the model of care that you describe is common for chronic conditions and needs to be part of that.

[34] **Rhodri Glyn Thomas:** So, we will see that document in the new year at some point, hopefully.

[35] **Ms Lloyd:** Yes.

[36] **Helen Mary Jones:** Do we have any idea at which point next year we might see that, as ‘next year’ is a long time?

[37] **Ms Lloyd:** It will be the beginning of next year. It should come to the Minister at the beginning of February.

[38] **Helen Mary Jones:** That is good to hear.

[39] To be clear, Ann Lloyd, you said that there should be no delay in patients accessing disease-modifying therapies if they are clinically assessed. So, if we get representations that suggest that there is a delay, there should not be any reason for that, and we can take it up directly with the Minister. There should not be an issue with getting the funding out. That is useful to know.

9.50 a.m.

[40] The paper says that the timescale for the review has yet to be finalised. If it is too much to ask what the timescale is for the review, could we at least ask for a timescale for

when the timescale might be finalised? [*Laughter.*] It would be helpful for people to know that.

[41] On the Health Challenge Wales voluntary sector grant scheme, you say, usefully, that one element will be for it to develop sustainability plans so that the work can continue beyond the funding period. Should organisations take that as a clear indication that they will need to look elsewhere for sustainability of funding, and that it is unlikely that a further three-year grant will be available, subject to evaluation? I accept what you say about needing to know whether these initiatives are adding any extra value and whether they give value for money. However, supposing the evaluations suggests that some or all of the initiatives do, and if it is your decision that they do—which it may or may not be after the elections—do you anticipate a further three-year scheme in line with the Assembly Government's commitment to funding organisations for at least three-year periods, or are we saying to those organisations that they have a year to sort themselves out with alternatives? It would be helpful for them to know one way or the other.

[42] **Brian Gibbons:** Ann may be able to answer that, but my understanding is that one reason why we have put in the evaluation phase, provisionally, is because it still has a couple of years to run but a fair amount of money is going into it. People have said that this is not a hard type of project in the sense of providing hard facilities, and so forth, but if we are putting this level of money into the scheme, we want to be assured that it is delivering the benefits. So, the idea is that the funding will run for two or three years, but, given that it is a big commitment of money, we need an evaluation at a reasonable stage in the process to see whether it is delivering. If the evaluation is positive, the funding will probably run its course; if the evaluation is more equivocal or is not good, we must pull back the money and look at how it can be spent in other ways. At the minute, the idea is that it will continue for a few years. In fairness, it brings some additionality to the scheme; the organisations that are involved bring their expertise and so on, so, theoretically, it is reasonably good value for money because of the commitment of these organisations. As long as the promise of the scheme is delivered, it is good all round for us, in promoting healthy lifestyles and so on.

[43] **Jonathan Morgan:** I am grateful to the Minister for the figures that he has provided. There are a couple of additional issues that I would like to raise. A view is being expressed by people in the Cardiff and Vale NHS Trust that if adult neurosurgery is sited at Swansea, paediatric neurosurgery would be lost, and the need for a paediatric intensive care unit would also be lost. Therefore, what you would have is a rather nice-looking district general hospital, but not a children's hospital. While I am not seeking to pre-empt any decisions that you will make on where adult neurosurgery will be sited, do you accept that there is merit in that particular view being expressed?

[44] A concern that will be raised with you when the plan is submitted is the issue of capital charges and how it is addressed. There are costs that health bodies may struggle to meet, and so, while you cannot give me a decision today because you need to see all the facts and figures, I ask you to give consideration to that particular problem when the plan is submitted to you.

[45] **Rhodri Glyn Thomas:** Hoffai nifer o Aelodau fynegi barn am y pwynt hwn. Yr wyf am wneud o'r gadair drwy ddweud nad wyf yn cytuno â'r farn y bydd symud gwasanaethau o Abertawe o reidrwydd yn cryfhau'r ddarpariaeth yng Nghaerdydd. Mae'n gwanhau'r ddarpariaeth yn Abertawe, ac, o ran fy etholwyr yn Nwyrain Caerfyrddin a Dinefwr, mae'n gwneud y sefyllfa yn anodd,

Rhodri Glyn Thomas: A number of Members would like to express an opinion on this point. I will express an opinion from the chair by saying that I disagree with the view that moving services from Swansea will necessarily strengthen provision in Cardiff. In fact, it weakens provision in Swansea, and, in relation to my constituents in Carmarthen East and Dinefwr, it makes

oherwydd ni allaf gael gwarant y bydd fy etholwyr yn cael y ddarpariaeth iechyd angenrheidiol o fewn yr amser sydd wedi'i gydnabod i fod yn dyngedfennol yn y materion hyn. Yr wyf yn parhau i boeni am y sefyllfa.

the situation difficult, because I cannot be guaranteed that my constituents will receive the necessary health provision within the time acknowledged as being essential for these matters. I remain very concerned about this situation.

[46] **Helen Mary Jones:** We should be focusing this discussion on the children's hospital. I accept that there is a knock-on effect, and, while Jonathan Morgan has been very clear in his expressions in the Chamber that we should not be seeking to micromanage these decisions, I am slightly surprised that he raised it in this context, but we will let him get away with it.

[47] **Jonathan Morgan:** If you had listened carefully to what I said, you would know that I was just asking the Minister whether he accepts the particular opinion that is expressed. I am not saying that it is my opinion, but concern is being expressed about the potential impact of that decision on the children's hospital, and whether the children's hospital is then a viable project. I was asking the Minister what his view was; I was not expressing my view and I was not expressing the view that we should be micromanaging the NHS.

[48] **Rhodri Glyn Thomas:** I should say from the chair that I am biased on this issue, but it should be pointed out that the decision to establish a children's hospital in Cardiff was taken before any discussions were undertaken about paediatric neurosurgery in Swansea. My view is that people who have raised that issue after the decision was taken are trying to cloud the issue. However, I admit that I am biased.

[49] **Jenny Randerson:** The issue is that the world has moved on in terms of clinical requirements. The minimum population that neurosurgery can serve is very much a twenty-first century requirement. Basically, we have to live in the world that we are in. In this respect, I urge the Minister to expedite this matter as quickly as possible once the new application is received. I recall that the last time I raised the issue of commissioning in relation to the children's hospital and the difficulty of getting so many commissioners to agree, the Minister gave me rather a sharp reply that I should not expect him to interfere in commissioning issues. I certainly would not expect him to make commissioning decisions, but, as Minister, I hope that he would require local health boards to take a consorted and co-ordinated view on commissioning, which is based on the very best clinical judgment, and not subject to local pressures and so on. I know that you may raise your eyes, but medical professionals are always saying to us that they want us to butt out of their job and let them get on with it, but, on the issue of neurosurgery, the Assembly has set down a challenge—we are offering to butt out of your job, and we are leaving it to you to come to an agreement. The medical profession needs to settle its differences and do that. In relation to the children's hospital, the same principle has to apply, but it should be done under ministerial guidance and a co-ordinated approach needs to be taken.

[50] **Rhodri Glyn Thomas:** This committee has no intention of butting out of any discussions on health—from now until 3 May at least.

[51] **Helen Mary Jones:** I have to say, Chair, that if I thought that we were going to have a discussion on where neurosurgery might or might not be sited, I would have come with appropriate notes to fight the case for west Wales, given that we have two people here who can ably fight the case for Cardiff, and are clearly doing so under a thin disguise.

[52] **Jenny Randerson:** I am not.

[53] **Helen Mary Jones:** Jenny, I did not interrupt you, so please do not interrupt me. Having said that, when we are in a situation where the medical profession does not agree, that

is the point at which political—with a small 'p'—decisions have to be made. The big difference between us and medical professionals is that we are elected and they are not. If they cannot agree—and strong cases are made on both sides by equally well qualified medical professionals—the point will come at which there has to be a political decision.

10.00 a.m.

[54] Coming back to the children's hospital, which is what I thought we were discussing, I would support what Jonathan Morgan says about capital charging, and hope that, when the proposals are in, you will be able to look at it. It is not within your gift to deal with it, but it is a bizarre tax on capital investment in the NHS, which I believe we would all dearly love to see shot of. However, since we cannot, in the case of this kind of level of strategic national development, which is the level at which the children's hospital should be, I hope that something could be done to mitigate some of the worst effects of that. I also support what Jenny Randerson said about making a decision as quickly as possible, given the high level of public interest, not only in the capital city, but across south Wales, and beyond, about this national development, and the amount of public giving that there has been to facilitate capital developments, and so on, so far. The sooner a decision can be made, the better, although, as we have all said, you cannot make that decision until you have the business case in front of you. However, I support the request to do it as fast as we can, once you and your officials have that information.

[55] **Brian Gibbons:** One reason why I wrote to HCW was that I believed that there was too much uncertainty, and too many unanswered questions, to make a decision that had such major ramifications for all health services across south Wales. I would be reluctant to give a strong personal view on that at this stage.

[56] However, the one thing that worried me, and one reason why I felt that we needed to wait, was the view that was submitted that specialist paediatric services in south Wales were so inherently unstable that it was pointless to fight to retain them. That view came from Swansea, which took the view that retaining specialist paediatric services in south Wales was inherently unsound. By implication, that meant that children from Carmarthenshire and Ceredigion will go to Bristol or Birmingham. Therefore, it did not seem to be the basis of winning an argument on access to adult neurosurgery, that children—and not just children needing neurosurgery, but those needing specialist paediatric services—would end up going out of Wales for those services. I believed that that was going to be a pyrrhic victory. That could not be the basis, as far as I was concerned, on which this issue would be resolved. However, that was fairly explicit in some of the submissions in terms of the case for adult neurosurgery. That is not acceptable to me.

[57] The challenge for us is to maintain the highest level—in terms of quality, safety and quantity—of specialist services in south Wales, including paediatric services, so that we have to come up with a solution that will give us a quality neurosurgical structure that will attract the best to Wales, and maintain that service at a high level of specialist expertise. However, we have to come up with some way of doing it to maintain, equally, the same type of service for children. It is unacceptable that people say that the paediatric specialist service is expendable. That view seems to have been expressed as a price worth paying to get adult neurosurgery. That is not my position.

[58] Therefore, this is why the specialist children's review is so important. As I understand it, the standards that will come out from that specialist children's review will give us an idea of the type of specialist children's services that we can expect to have in south Wales, based on population and what the population base is to maintain these services, and so on. Therefore, that specialist children's review is important to try to deal with the stability of specialist paediatric services.

[59] However, one of my priorities is keeping these services in south Wales. Making a decision that undermines stability or forces children from west Wales, or anywhere else, to leave Wales for specialist paediatric services is not an answer. That is one of the reasons why I felt that we needed to step back from our position in this process. Yesterday, the Healing Foundation gave a grant of £10 million, which is absolutely brilliant news and an excellent opportunity for Wales, on the basis of Cardiff University, Morriston Hospital and Swansea University working together. If we are going to maintain quality services in Wales, parochial concerns have to be taken out of the equation. People must ask, 'What is in the interest of patients?', and that must be the starting point. I agree that we need better fora for discussing these issues, which will be able to rise above what is either local empire-building or concern that services are being taken away in some sort of mechanical way and that everything will be centralised in Cardiff.

[60] The reform of the professional advisory structure, which we may have passed over a little quickly, is the first step in doing this and we really must have a strong, resilient professional advisory structure, within which some of these decisions will be taken on the basis of what is clinically required and what is in the best interest of patients. The names should be taken off the towns, and the question should be, 'Where is this service best done?', and then the names should be put back in afterwards. We need to be able to do that. I do not know whether it is appropriate, Chair, for the CMO to give some—

[61] **Rhodri Glyn Thomas:** Credaf ein bod i gyd yn gytûn ar yr angen i amddiffyn gwasanaethau yn ne Cymru, fel y byddem hefyd yn amddiffyn gwasanaethau yng ngogledd Cymru. Yr wyf yn credu ein bod yn gytûn ar hynny. Yr wyf yn ymwybodol nad wyf yn cadeirio'r eitem hon yn ddiduedd, oherwydd bod gennyf deimladau cryf ar y pwnc. Yr wyf yn teimlo'n gryf, a gwn fod nifer o Aelodau yn rhannu fy mhryderon, fod tuedd i edrych ar symud gwasanaethau o Abertawe fel ffordd o amddiffyn gwasanaethau yn ne Cymru, ac nid ydym, o reidrwydd, yn derbyn y ddadl honno. Fodd bynnag, yr ydym yn gwbl gytûn â chi ac yn falch o glywed eich bod yn teimlo mor gryf am yr angen i gadw gwasanaethau yn ne Cymru ac na ddylai gwasanaethau symud yn naturiol i Fryste.

Rhodri Glyn Thomas: I believe that we all agree on the need to safeguard services in south Wales, just as we would safeguard services in north Wales. I believe that we are agreed on that. I am aware that I am not chairing this item impartially, because I have strong feelings on the subject. I feel strongly, and I know that many Members share my concerns, that there is a tendency to see moving services from Swansea as a way of safeguarding services in south Wales, and we do not necessarily accept that argument. However, we are in complete agreement with you and we are glad to hear that you feel so strongly that there is a need to keep services in south Wales and that services should not move naturally to Bristol.

[62] Ar y nodyn unedig hwnnw, symudwn ymlaen at eitemau 9 i 13.

On that united note, we will move on to items 9 to 13.

[63] **Helen Mary Jones:** On item 9, which is about car parking and telephone charges, I am grateful to the Minister and his officials for the information. It seems clear to me that the information throws up a mixed picture across Wales, which, I submit, is an inequitable picture. Does the Minister have any plans to develop some good practice guidance for trusts, so that we begin to get some fairness across Wales on this? I am also interested to know—and I have not made the correlation personally—whether there is any correlation between the trusts that feel that they need to create income from things such as car parking and telephone charges and those trusts that are not getting what they should be getting under the Townsend formula? I obviously have a particular interest in Carmarthenshire, because that is where I live. It seems to me that that correlation may not be there, but it would be interesting to know

whether there are reasons why trusts feel that they need this extra income. Could we have any national guidance on this and does the Minister have any plans to revise the hospital travel costs scheme to take the cost of car parking charges into account more effectively, particularly for cancer patients, for example, who have to go for repeated treatments? People may think this a trivial issue, but it is not trivial if you are on benefits and have to attend hospital daily for a considerable time, or if you have a very ill or dying relative. A lady in my region talked about having to leave her dying son's bedside to put coins in a parking meter—I do not think that any of us would think that that was right. Perhaps we can have some national guidance on the management of these things, detailing, if there are any charges, what sort of exemptions there should be. We should consider whether there is a more equitable national way of dealing with this. When you look at the national picture, it is so patchy, and inexplicably so.

10.10 a.m.

[64] **Brian Gibbons:** The situation at this stage is that this is the responsibility of trusts. Because trusts exist in this semi-autonomous way, with areas such as this, you will see variation. That is the essence of why trusts were set up in this way. You ask whether the charging reflects the financial position of the organisations, but I am not sure whether it does. The first one there is Bro Morgannwg, which is one of the best trusts in Wales all round. Bro Morgannwg, for sure, would have to be outside the association that you make. Obviously, it is an intuitive sort of thing to say.

[65] **Helen Mary Jones:** I was asking the question because I did not know whether there was a link.

[66] **Brian Gibbons:** The answer is, 'Probably not'. With regard to the future, I hope it is not too blatant a political point to make, but in the document that emerged from the Labour Party policy forum that will form the basis of our manifesto, there is a commitment to the review of hospital charges so that, if we get a mandate in May, we, as an administration, will be bound by that to review hospital parking charges. Clearly, we will have to take that on board if we are given the mandate to do that.

[67] With regard to the telephones, it is probably true that the old way of looking at mobile phones as being dangerous in all parts of hospitals and so on is outdated. I have seen a copy of a good advice document from Bro Morgannwg, which it circulates to visitors, staff and so on, and we are looking at that guidance as a template to the NHS more generally on the use of mobile phones, bearing in mind that, if people can use mobile phones on a ward, for example, you do not want a patient in one bed hearing a mobile phone going off in the next bed, or people engaged in long chats on their mobiles, as seems to happen on trains and elsewhere. There are issues of how people use mobile phones, but, clinically, such use is fairly safe, and we need to update guidance on that, and the Bro Morgannwg document is a good template.

[68] Bro Morgannwg is also, in some cases, looking at using the internet for telephone calls so that, instead of people having to use their own mobile phones, they will have a portable, internet-linked console that they can use to make fairly cheap calls. It is a bit like the present system, which uses those little units by the bed, but this will be linked into the hospital telephone network and brought along to the bedside—a bit like landlines are brought to bedsides now. That is something that some of the trusts are looking at. However, with regard to telephones, the guidance will go out and change the situation in relation to their use.

[69] **Jenny Randerson:** Returning to the matter of car parking, I am aware that it is a complex situation. Some trusts have inherited contracts, have they not? There is also the issue of the geographical situation. If you take the Royal Gwent Hospital, for example, if it did not charge for car parking, everyone who worked in the centre of Newport would park there,

would they not? So, it is a very complex issue. However, it concerns me that there is a phrase in the report that states that many trusts have reduced rates for frequent attendees. It would be useful to have guidelines very soon to say that they should all have reduced rates for people who have to attend frequently.

[70] The other half of the equation is not here, Minister. You have noted how much they raise, but you have not noted what they spend the money on. I saw a dreadful *Daily-Mail*-style headline, although it might not have been in the *Daily Mail*, about trusts lining their pockets with income from car parking. It is as if the members of the trusts are personally pocketing the money. If they are using the money for something that is a core service, it would be useful for us to know that. Having asked some questions through the Members' research service some months ago, I know that the money is used for all sorts of useful things.

[71] **Brian Gibbons:** Historically, car parking and so forth was a relatively low priority. When the health service was under severe financial pressure, car parking, generally, was one of those things that were not prioritised. Staff could not leave their cars securely, so security staff had to be appointed and barriers had to be put in. I think that that is probably where it started. We tried to get some idea as to what the security staff and the upkeep of the car parks cost, but I think that the answer that we had was that it would be very difficult and disproportionately expensive to disentangle the total cost of the car parks maintenance, security staff, metering, and so forth.

[72] This is the income that comes from car parking, but we do not really know what the expenditure is for maintaining the car parking facilities. Anything else that goes into the rest of the health service would only follow—[*Inaudible.*]—the car parking, what is necessary to upkeep and maintain those car parking facilities; any surplus would only then be available for the health service. Therefore, I think that it is very difficult to give specific figures for how much is actually going into clinical services. Presumably, the trusts that are not charging for car parking and so forth, are taking money, effectively, from clinical services to cover the costs of the car parking. I cannot see how else they would be doing it. As Jenny said, some trusts are bound up in commercial contracts, such as the University Hospital of Wales, and there will not be anything much that we can do about those until contracts run their course.

[73] **Jonathan Morgan:** I have a very quick point on car parking before I move on to point 12. When you look at where some hospitals are located, such as the University Hospital of Wales, you see that not only it is next to a very busy road but it is also fairly close to a residential area. I just wish that, in that circumstance, the local authority was more sympathetic to the needs of residents who live near the site. It is not just the impact on people's pockets of parking their cars at the hospital—although, to be fair, £2 for four hours is not exactly excessive compared to what you would pay in an NCP car park in the centre of Cardiff—but there is an impact on the surrounding streets. It does not always make it easy for relationships between people living near the hospital and the hospital trust itself. Sometimes, staff are minded to park their cars in residential streets. It is a great shame that no more is done to encourage a little more working together between NHS trusts and local authorities in those sorts of situations, to resolve the problem.

[74] On point 12, the issue of organ donation, the British Kidney Patient Association and other groups are very keen on the notion of presumed consent, whereby people opt out as opposed to opting in. What is the Government's view on that issue?

10.20 a.m.

[75] **Brian Gibbons:** I would prefer not to answer. I think that this is a step forward. The First Minister has taken the view—and there is a lot to commend it—that when somebody volunteers, it is an act of giving and the fact that so many people are willing to positively sign

up to an act of giving in terms of organ donation shows some intrinsic value in the culture of our society. There are good reasons for it to become compulsory. Professional organisations, such as the British Medical Association, believe in that. So, there is a good argument too for people to have to opt out rather than opt in. There is a debate to be had around that. I do not want to declare my own view on it, but part of the concept that this is an altruistic gesture by people is an important point in terms of how we function as a society in that we do not have to be dragooned into having our organs removed regardless of our wishes. A transplant is particularly beneficial for kidney patients and you can well understand why they would take the view that we need to have a more resilient system and that if people do not like it, the onus should be on them to opt out. I would not try to argue that there is not a strong merit in that point.

[76] **Rhodri Glyn Thomas:** Yr wyf yn ymwybodol nad wyf yn cadeirio'r sesiwn hon yn arbennig o ddiduedd gan fod gennyf, eto, deimladau cryf iawn ar eitem 12. Credaf y dylid sefydlu system lle mae pobl yn gorfod optio allan. Rhaid inni ystyried hynny yng nghyd-destun yr angen am drawsblaniadau. Weinidog, beth yw eich cynlluniau ar gyfer sicrhau bod mwy o gyfle i gyflawni trawsblaniadau yng Nghymru? Yr wyf yn ymwybodol bod y capasiti sydd gennym ar gyfer trawsblaniadau yn fach iawn. A oes gennych fwriad i edrych ar hynny?

Rhodri Glyn Thomas: I am aware that I am not chairing this session particularly impartially, as, on item 12, I again have very strong feelings. I believe that we should establish a system whereby people have to opt out. We must consider that in the context of the need for transplants. Minister, what are your plans for ensuring that there are more opportunities to undertake transplants in Wales? I am aware that the capacity that we have for transplants is very small. Do you intend to look at that?

[77] **Brian Gibbons:** The numbers have gone up from the mid 70s to the 90s now. We have always taken the view that, even if someone is the ninety-first person to need a kidney transplant, if a suitable donor comes along, the transplant should be made available to them. Our capacity has gone up from the mid 70s to about the 90s. Clearly, the need for transplants is there and, without any doubt, the capacity needs to grow. We have done that. Equally, the renal national service framework—I do not know whether or not the consultation has finished yet—talks about dialysis and other support services as well as transplants, but clearly there is a need for more transplants. One of the rate-limiting factors is the donors. There is no question about that.

[78] **Rhodri Glyn Thomas:** Fe'ch cyfeiriaf at bwynt 13. Yr ydych yn sôn yno am y ffaith bod Llywodraeth y Cynulliad yn cynnig £700,000 i'r gwasanaeth Cyngor ar Bopeth er mwyn sicrhau bod y gwasanaeth Cyngor Da: Iechyd Da yn parhau. A yw'r gyllideb honno'n ddiogel hyd at fis Mai nesaf?

Rhodri Glyn Thomas: I refer you to point 13. You talk there about the Assembly Government's offering £700,000 to Citizens Advice to ensure that the Better Advice: Better Health service continues. Is that budget safe until next May?

[79] **Brian Gibbons:** Yes, I think that the £700,000 is safe. That is a good scheme. Our only regret is that we cannot expand it. We have just had a case for disease-modifying drugs. We could have taken some of that money and put it into this scheme or we could have put it into something like the risk-sharing scheme for MS. Those are the sort of difficult decisions that we have to make in terms of resource allocation.

[80] We are certainly committed to maintaining the scheme as it is and, if possible, we would like it to continue, because I think that it has been an excellent scheme and a great number of people have benefited from it, which is fantastic. I spoke to Fran Targett and she said that they have been able to lever in some additional money to the scheme, so that this £700,000 has been useful as a cornerstone for the service that they are providing. They have

been able to bring a little more in from other sources because they have certainty in relation to the £700,000. There is no doubt, from what we gather from Citizens Advice, that this has been extremely successful and, if more money was available, they would be able to do an awful lot more work. It is difficult; it is a case of how we decide on the allocation. I would certainly be very happy for more to go into that scheme, if the opportunity presented itself.

[81] **Rhodri Glyn Thomas:** Gan fy mod wedi bod yn ymwrthod â bod yn ddiduedd drwy'r bore, yr wyf yn mynd i beidio â bod yn ddiduedd eto a dweud fy mod yn credu bod y cynllun hwn yn arbennig o bwysig. Yr wyf yn falch o weld bod yr arian wedi ei ddiogelu, ond byddwn yn croesawu arian ychwanegol ar gyfer y cynllun hwn gan fy mod yn credu ei fod yn fuddsoddiad arbennig o bwysig gan ei fod yn cynnig gwasanaeth hollbwysig i bobl Cymru. Gobeithiaf y bydd y Gweinidog yn chwilio am gyfleoedd i ychwanegu at y swm hwn—sy'n swm cymharol fach o fewn y gyllideb iechyd. Derbyniaf fod pwysau ar ei gyllideb o bob cyfeiriad, ond byddai'n wych pe bai'n gallu canfod ychydig o gannoedd o filoedd ychwanegol yn rhywle i gefnogi'r cynllun hwn.

Rhodri Glyn Thomas: As I have abstained from being impartial all morning, I will once again not be impartial and say that I believe that this scheme is very important. I am glad to see that the money has been safeguarded, but I would welcome additional money for this scheme because I think that it is an especially important investment as it offers an all-important service to the people of Wales. I hope that the Minister will look for opportunities to add to this sum—it is a comparatively small sum in terms of the health budget. I accept that there are pressures on his budget from all directions, but it would be wonderful if he could find a few hundred thousand pounds from somewhere to support this scheme.

[82] Os nad oes unrhyw bwyntiau ychwanegol ar adroddiad y Gweinidog, symudwn ymlaen.

If there are no more points on the Minister's report, we will move on.

10.27 a.m.

Rhestr o Is-ddeddfwriaeth
Schedule of Secondary Legislation

[83] **Rhodri Glyn Thomas:** Mae'r is-ddeddfwriaeth newydd wedi ei gysgodi yn y ddogfen. Yr wyf yn barod i ystyried ceisiadau os ydych wedi gweld rhai pethau sydd eisoes wedi eu nodi yr ydych am eu codi. Yr wyf yn barod i drafod y rheini. Weithiau yr ydym yn nodi is-ddeddfwriaeth i ddod yn ôl i'r pwyllgor heb gynnig pwyntiau o eglurhad na gwelliannau, ond derbyniaf fod unrhyw gonsýrn neu amheuon oedd gennych chi yn diflannu erbyn i chi weld yr is-ddeddfwriaeth.

Rhodri Glyn Thomas: The new secondary legislation has been shaded in the document. I am willing to consider requests if you have noticed anything that has been noted previously that you wish to raise. I am willing to discuss those. We sometimes note secondary legislation that is to be brought back to committee without tabling explanatory points or amendments, but I accept that any concerns or doubts may disappear by the time that you see the secondary legislation.

[84] **Helen Mary Jones:** On that point, Chair, we do not know if we need to make amendments until we have an opportunity to scrutinise the legislation. If we have asked to look at it, and we look at it and are then content, that does not necessarily mean that we should not have identified it for scrutiny.

[85] I have a couple of points on regulations that we have noted before. On HSS 45, it says that the regulations are

[86] 'to change and clarify the rules of eligibility of overseas visitor to receive free primary medical services'.

[87] The note that we have says that the amendments to the regulations have been suspended due to a Department of Health decision, post consultation. I would like to know what that decision was and whether we have an indicative timeframe for when these regulations might or might not be made.

[88] The other point was on HSS 71, the Independent Prescribers Regulations 2005. The course of these regulations is grinding exceedingly slowly and I just wondered whether there was any capacity to bring the regulations to Plenary before February. I do not think that they are controversial and I think that we have all supported them—the opposition parties have certainly supported the need for independent prescribing for many years. I know that it is only a matter of months, but I hope that there is a way of speeding it up; given that it is unlikely to be controversial, it may not even be subject to much debate.

[89] **Rhodri Glyn Thomas:** Ar y pwynt hwnnw, credaf i ni gytuno yn y cyfarfod pwyllgor diwethaf ar y mater hwn. Ysgrifennais at Gadeirydd y Pwyllgor Busnes, sy'n digwydd bod yn aelod o'r pwyllgor hwn hefyd, a gobeithiwn y bydd y ddeddfwriaeth honno yn ymddangos yn gynnar iawn. Deallaf mai ym mis Ionawr y bydd yn ymddangos.

Rhodri Glyn Thomas: On that point, I think that we agreed in the last committee meeting on this matter. I wrote to the Chair of the Business Committee, who also happens to be a member of this committee, and we hope that that legislation will be brought forward very soon. I understand that it will be in January.

[90] **Brian Gibbons:** I am not familiar with the details in relation to the eligibility for treatment, but we will try to get a note to you on that. We can certainly take that away and find out where they are. Given that we leapfrogged the medicines use review regulations, that would have put back the work on the independent prescribing a little because it is largely the same people who are doing that work, so, with the committee's co-operation, the fact that we were able to bring that forward involved a fair commitment by our staff, but we will see whether we can get an answer for you on that. I would not want to make any definitive promises, because I know that it was difficult for them to get in the medicines use review regulations because of this committee's view and that of Community Pharmacy Wales.

[91] **Rhodri Glyn Thomas:** Diolch, fe edrychwn ar hynny yn y cyfarfod nesaf ar ôl cael nodyn gan Gweinidog.

Rhodri Glyn Thomas: Thank you, we will look at that in the next meeting after we receive a note from the Minister.

[92] **Jenny Randerson:** On the new legislation identified, HSS 44 (06) and HSS 45 (06), which are the Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment No. 3) Directions 2006, which is about the administration of vaccines, and Local Health Board (Childhood Immunisation Programme) Directions 2006, seem to be linked together in terms of topic. I think that we should look at that because there are concerns about levels of immunisation and so on and take-up, particularly in some parts of Wales. I think that it would be useful for us to look at those.

[93] **Rhodri Glyn Thomas:** Credaf fod cytundeb y dylem edrych ar hynny yn y pwyllgor. Gwelaf fod nifer o bobl yn cefnogi sylwadau Jenny, felly daw hynny yn ôl i'r pwyllgor. A oes unrhyw sylwadau eraill ar yr is-ddeddfwriaeth? Gwelaf nad oes.

Rhodri Glyn Thomas: I think that there is agreement that we should look at that in committee. I see that many people agreed with Jenny's comments, and therefore, that will come back to committee. Are there any other comments on items of subordinate legislation? I see that there are none.

10.31 a.m.

Is-ddeddfwriaeth: Rheoliadau Comisiynydd Pobl Hŷn Cymru a Rheoliadau Comisiynydd Pobl Hŷn Cymru (Penodi) 2006 a Rheoliadau Mangreoedd Di-fwg etc (Cymru) 2007
Secondary Legislation: the Commissioner for Older People in Wales Regulations and the Commissioner for Older People in Wales (Appointment) Regulations 2006 and the Smoke-Free Premises etc (Wales) Regulations 2007

[94] **Rhodri Glyn Thomas:** Os cofiwch, yn y cyfarfod diwethaf, dywedais os nad oedd unrhyw bwyntiau o eglurhad neu welliannau wedi eu cynnig, ni fyddem yn cynnwys yr eitemau hyn ar yr agenda, ond fel y gwyddoch, gan eich bod wedi derbyn nodyn gan y Gweinidog, cyflwynwyd mân newidiadau i Reoliadau Mangreoedd Di-fwg etc (Cymru) 2007 gan Lywodraeth Cymru, felly yr ydym wedi gadael yr eitem honno ar yr agenda rhag ofn fod rhywun yn dymuno cyfeirio at y mân newidiadau hynny. Fodd bynnag, yr wyf yn barod i'w derbyn dim ond sylwadau ar y mân newidiadau ar y rheoliadau hynny.

Rhodri Glyn Thomas: If you remember, in the last meeting I said that if no points of clarification or amendments had been proposed, we would not include these items on the agenda, but as you know because you have received a note from the Minister, some minor changes were introduced to the Smoke-Free Premises etc (Wales) Regulations 2007 by the Welsh Assembly Government, and therefore, we have left this item on the agenda in case anyone wanted to comment on those minor changes. However, I will accept comments only on the minor changes to those regulations.

[95] Ar eitem 4, y comisiynydd ar gyfer bobl hŷn, codwyd un pwynt o eglurhad gan Jenny Randerson ac y mae ar gael yn bapur 3 os ydych am edrych arno.

On item 4, on the commissioner for older people, a point of clarification was raised by Jenny Randerson and it is outlined in paper 3 if you want to look at that.

[96] **Jenny Randerson:** I think that there is a slight error in the numbering, which probably happened at my end, because I dictated it down the phone. If you look at the regulations, and section VI on the last-but-one page in your papers, which is page 12 in my printout, under paragraph 16 (i) and (ii) it says that the commissioner may make a report to the Assembly in connection with the exercise of any of his or her general functions. To me, that implied a report on specific cases or issues. Under (ii), it states that the commissioner must make an annual report to the First Minister. In the past, annual reports have come to the Assembly, and I know that we will be in a brave new world, but I was interested in why that annual report would not go to the Assembly, given that he or she will be an independent commissioner and, therefore, would not be Government-controlled, if you see what I mean.

[97] **John Griffiths:** Jenny, I think that you make a good point, because obviously there is an inconsistency there. Although it is an annual report to the First Minister, it would come to the Assembly for debate as does the children's commissioner's annual report. However, now that we have added this ability to report in terms of general functions, there is now an inconsistency between the two. It probably would be better if we were consistent and we changed the reporting requirement regarding the annual report to a requirement to also to report to the Assembly. We could do that following this meeting.

[98] **Jenny Randerson:** I am grateful.

[99] **Jonathan Morgan:** On that point, if you are going to make that alteration, although it would be a slightly different set of regulations, can I suggest that you make the same change

with regard to the children's commissioner? It makes sense that if the older person's commissioner makes the annual report to the Assembly, as opposed to the First Minister, the same should follow naturally for the children's commissioner.

[100] **Rhodri Glyn Thomas:** Mae'r pwynt hwn wedi ei godi ar nifer o achlysuron. Yr wyf yn ymwybodol fod cefnogaeth sylweddol ymysg Aelodau'r Cynulliad ar gyfer y math hwn o drefn, oherwydd os yw Comisiynydd Plant Cymru yn adrodd yn ôl i bwyllgorau, ni fyddai Aelodau eraill sydd am fynegi barn ar ei adroddiad yn cael y cyfle i wneud hynny. Felly, gobeithiaf y bydd y Dirprwy Weinidog a'r Gweinidog yn ystyried y materion hynny. Hwyrach y gallwch ein hysbysu o'ch dyfarniad ar ôl ichi gael cyfle i'w hystyried.

Rhodri Glyn Thomas: This point has been raised on a number of occasions. I am aware that there is substantial support among Assembly Members for this arrangement, because if the Children's Commissioner for Wales reports back to committees, other Members who may wish to express an opinion on his report would not have the opportunity to do so. Therefore, I hope that the Deputy Minister and the Minister will consider those issues. Perhaps you can inform us of your decision after you have had the opportunity to consider them.

[101] **John Griffiths:** On that issue, the current requirement to report to the Assembly will become a requirement to report to Ministers after May of next year. That is how I understand the position, so it may be that the distinction may not be that important given what will happen after next May, and the proximity of next May.

[102] **Rhodri Glyn Thomas:** Yr wyf yn derbyn pwynt pwysig y Dirprwy Weinidog, oherwydd bydd y drefn yn newid yn gyfan gwbl ar ôl 3 Mai. Yn ôl fy nealltwriaeth o'r sefyllfa, ni fydd y math hwn o pwyllgor yn bodoli fel pwyllgor sy'n cyfarfod yn gyson ar ôl 3 Mai. Felly, bydd yn rhaid i edrych ar hyn, ond o ran atebolrwydd yr adroddiad hwnnw a'r cyfle i Aelodau fynegi barn arno, gobeithiaf y bydd unrhyw Lywodraeth ar ôl 3 Mai yn edrych ar y sefyllfa i weld sut y gellir sicrhau fod pob Aelod Cynulliad yn cael y cyfle i fynegi barn ar y math hwn o adroddiad, sy'n amlwg yn bwysig i bawb.

Rhodri Glyn Thomas: I accept the important point that the Deputy Minister makes, because the arrangements will change completely after 3 May. From my understanding of the situation, this type of committee will cease to exist as a committee that meets regularly after 3 May. Therefore, we must look at this, but in terms of the report's accountability and the opportunity for Members to express an opinion on it, any Government after 3 May will, hopefully, look at the situation to ensure that every Assembly Member has the opportunity to express an opinion on this type of report, which is obviously important to everyone.

[103] **Helen Mary Jones:** The Deputy Minister is right when he says that that will be the norm, but it is not my understanding—Jenny Randerson would know better than I—that the new Standing Orders would insist that the Westminster model is slavishly followed. It will be for the new Assembly to decide, but there may be an argument for the reports of the commissioners, which are meant to be independent of Government, to continue to be made to the Assembly. It would not be the norm in Westminster, but we did not have devolution in order to do everything exactly as is done in Westminster, even given the separation of powers. I do not propose that we have an extended debate about it now, but, from my understanding, there would not be anything that would prohibit specific regulations from making an exception, for these special roles, which are not comparable to other public bodies and so on, to the norm that these reports and similar reports should be made to Government. It will be for the new Assembly to decide, but I am just putting on record that I do not think that it is inevitable that we must throw the Welsh democratic baby out with the fudged bathwater.

[104] Rhodri Glyn Thomas: Nid wyf yn awyddus i grwydro i drafodaeth am hyn, ond

Rhodri Glyn Thomas: I am not eager to stray into a discussion about this issue, but I

yr wyf yn gweld bod Jenny Randerson yn dymuno ymuno â'r drafodaeth hon. Nid wyf am grwydro i drafodaeth am y drefn a gaiff ei dilyn ar ôl 3 Mai, ond credaf bod barn gref yn y pwyllgor y dylid sicrhau bod yr adroddiadau hyn yn dod i sylw bob Aelod Cynulliad, yn hytrach na dim ond i sylw'r Llywodraeth a'r Gweinidogion.

see that Jenny Randerson wishes to join this discussion. I do not want to stray into a discussion about arrangements after 3 May, but I believe that there is a strong view in the committee that it should be ensured that these reports come to the attention of every Assembly Member, and not just to the attention of Government and Ministers.

[105] **Jenny Randerson:** I cannot give you a simple answer on that, and it would not be appropriate to do so. There is a view that the reports of the independent commissioners should be fully aired in the Assembly in the future. However, in case people have picked up on your words, Chair, I just wanted to correct you, if you do not mind me putting it that way. Current discussions in the Committee on Standing Orders do not suggest that subject committees will disappear. It is unlikely that there will be as many subject committees, so your empire might be wider, but the concept will stay. Their functions will change slightly, but scrutiny will be included.

10.40 a.m.

[106] **Rhodri Glyn Thomas:** Diolch am y pwynt hwnnw. Yn sicr, fel rhywun sydd wedi bod yn dra chefnogol i graffu am y saith mlynedd ddiwethaf, ac wedi cadeirio tri phwyllgor yn y Cynulliad, gan geisio sicrhau bod craffu'n digwydd yn y pwyllgorau hynny, ni fyddem eisiau gweld hynny'n diflannu. Yr oeddwn yn mynegi barn ynghylch y byddai natur y pwyllgor yn newid ar ôl Mai, ond yr wyf yn barod i gefnogi pwynt Jenny Randerson. Oes sylwadau ar y mân newidiadau i'r rheoliadau? Yr wyf wedi cadw'r eitem ar yr agenda oherwydd y mân newidiadau, er yr oeddwn yn tybio na fyddai sylwadau, a gwelaf nad oes.

Rhodri Glyn Thomas: Thank you for that point. As someone who has been very supportive of scrutiny for the past seven years, having chaired three committees in the Assembly, and having tried to ensure that scrutiny happened in those committees, I would not want to see that disappear. I was expressing an opinion that the nature of the committee would change after May, but I am happy to support Jenny Randerson's point. Are there any comments on the minor changes to the regulations? I have kept the item on the agenda because of the minor changes, but I thought that there would not be any comments, and I see that there are not.

[107] Awgrymaf ein bod yn ymlaen, oherwydd mae yna 20 munud yn weddill cyn y toriad. Felly, symudwn at eitem 6, os yw'r Gweinidog yn hapus i'w wneud a'r swyddogion priodol yn bresennol. A ydych yn hapus i wneud hynny, Weinidog?

I suggest that we move on, because we have 20 minutes before the break. Therefore, we will move to item 6, if the Minister is happy to do that and the appropriate officials are present. Are you happy to do that, Minister?

[108] **Brian Gibbons:** No, I am afraid that I am not.

[109] **Helen Mary Jones:** Shall we look at the committee forward work programme instead?

[110] **Rhodri Glyn Thomas:** Symudwn felly i eitem 7, ac fe dorrwn yn gynharach, a dychwelyd, hwyrach, am 11 a.m..

Rhodri Glyn Thomas: We will therefore move to item 7, and we will break earlier, and come back, perhaps, at 11 a.m.

10.41 a.m.

Blaenraglen Waith y Pwyllgor—Ionawr i Mawrth 2007
Committee Forward Work Programme—January to March 2007

[111] **Rhodri Glyn Thomas:** Mae Jenny i ddechrau.

Rhodri Glyn Thomas: Jenny is to start.

[112] **Jenny Randerson:** I suggest that on 25 January we will need longer than 30 minutes to look at the report into the Welsh ambulance services. That probably presents you with a problem, but I think that we need longer. We also need to find a slot somewhere to follow up on the all-Wales medicine strategy group, because the Minister said that he would provide us with further information in due course, as to how the relationship between that group, the Scottish group and the relationship with the National Institute for Health and Clinical Excellence, will work in practice. You said that discussions were at an advanced stage and that you were optimistic, but we would like some sort of report. You may want to include it in a ministerial report, but I just wanted to have the opportunity to draw attention to it.

[113] **Rhodri Glyn Thomas:** Credaf fod gytundeb ar y ddau bwynt. Deallaf fod adroddiad sylweddol a diddorol yn mynd i gael ei gyhoeddi ddydd Llun gan Swyddfa Archwilio Cymru ar wasanaethau ambiwlans. Er ei fod yn creu problemau enfawr o ran y flaenraglen waith, yr wyf yn gweld bod pwyntiau sydd angen ei trafod a fydd yn cymryd mwy na hanner awr. Yr wyf yn nwylo aelodau'r pwyllgor o ran dewis a dethol yn ofalus iawn beth maent yn ei wneud o ran materion eraill ar yr agenda er mwyn sicrhau ein bod yn diogelu'r amser hwnnw.

Rhodri Glyn Thomas: I think that there is agreement on both points. I understand that there is a comprehensive and interesting report being published on Monday from the Wales Audit Office on ambulance services. Although it will create massive problems in terms of the forward work programme, I can see that there will be points that will need to be discussed that will take up more than half an hour. I am in the hands of committee members in terms of their making careful choices regarding what they do with other matters on the agenda to ensure that we safeguard that time.

[114] **Jonathan Morgan:** I wish to endorse the view that Jenny expressed. When you look at 25 January, we have the report of the chief inspector of Healthcare Inspectorate Wales, and I am not entirely sure whether it is absolutely necessary for us to take that on that particular day. I would certainly favour a greater amount of time being allocated to the review of ambulance services, over and above the chief inspector's report.

[115] **Rhodri Glyn Thomas:** On that point, if Members will be concise and raise specific issues, we can curtail that item to half an hour, which will allow us another half an hour on the ambulance services. I am in the hands of Members here, and if you want to prioritise items on the agenda, we will make time available for them.

[116] **Jonathan Morgan:** It is a good idea. I also endorse the view with regard to the all-Wales medicine strategy group. Finally, Chair, I would like to place my concern on record—and it is not a criticism of you, but perhaps of the way in which this has been handled—that the review into ambulance services was ordered by the Assembly by means of a motion, and was not requested by the Audit Committee. I understand that the current framework allows the Audit Committee to consider a report by the auditor general, because that is the format that is followed. However, I think that it should have come to this committee first, before being considered by the Audit Committee, because it gives the impression that it was something that was being driven by the Audit Committee. It was not; it was requested by the Assembly as a whole. I suspect that it is purely Standing Orders or the legislative framework that demands that that take place, but the Audit Committee is going to spend an entire day examining this report the week after next.

[117] **Rhodri Glyn Thomas:** I raised this matter in the Panel of Chairs meeting this week, and I made my views clear. I am deeply unhappy about the situation. This matter was raised in this committee, the terms of reference were discussed in this committee, this committee asked Jeremy Colman to undertake that review, and so my view is that it should have come back to this committee for consideration. However, Standing Orders state clearly that a report by the Wales Audit Office goes first of all to the Audit Committee. I agree with Jonathan, in that I do not believe that this was a normal review by the auditor general. I made my views clear, and the Presiding Officer has agreed that we should look at that situation.

[118] **Jenny Randerson:** We could, of course, have suspended Standing Orders in this respect. We could have tabled a motion to Plenary to cover us when we realised that this was happening.

[119] **Rhodri Glyn Thomas:** Yes, we certainly could have done that.

[120] **Helen Mary Jones:** I share those concerns. I do not believe that it is a question of the Audit Committee deliberately deciding to take this over, because I know that the Chair explored ways around this. I do not believe that we thought about suspending Standing Orders, but, within Standing Orders, there was no other way to do it. However, we are where we are.

[121] Jonathan has made the point that members of the Audit Committee, who are expert auditors but are not politicians with expert health background, will spend a whole day discussing this. I am about to commit a cardinal sin by suggesting that we may need a special meeting, even though I know that that is nightmare diary hell, and that it is an incredibly busy time for everyone. I have not discussed this with colleagues, and I do not know whether other people would agree to a special meeting. However, given that this matter is of such seriousness—it came out of a minority party debate, but it was agreed by the whole Assembly, and the terms of reference were agreed by this committee—there would be something profoundly odd about a situation in which the Audit Committee, which did not ask for this inquiry, did not commission it, and did not set its terms of reference, spends a whole day on it, when we are talking about jiggling around an ordinary committee agenda to find just an hour to discuss it.

[122] We have no knowledge of what may or may not be in the report, or of whether the matters that are likely to come up are audit matters in the traditional sense—financial responsibility, and so on—or policy matters. We do not know that yet; I suspect that it will possibly be both. However, is there any capacity to look at that? I would be prepared to look seriously at trying to clear half a day in my diary for a committee slot. That would not be easy for any of us, and we have the Minister's diary and his officials' diaries to consider as well, but could we do that?

[123] I have another point to make, but I do not know whether we will be able to accommodate it in our programme. Do you want to come back to this point, Chair?

[124] **Rhodri Glyn Thomas:** Yes, I will come back to you on that point. I am happy to look at that suggestion, because, initially, I had not put this issue on the agenda purely because I thought that it would be irrelevant for us to discuss it in the new year. It is being announced next Monday, and, by the time we could schedule it into our diaries, I felt that any discussions that we could have had then would be less worthy perhaps than had they been sooner. I take on board what Helen Mary Jones is offering here, and I can see that other Members support that idea. I would certainly be keen to devote a few hours to it. My understanding is that it will be a substantial report, and I am not sure what we can do in only an hour. I realise that we cannot discuss the contents of the report, but my understanding is

that it is a substantial report, with wide-ranging recommendations. I do not know what your position is, Minister. Would you be available if we discussed the possibility of scheduling an additional meeting with your office?

10.50 a.m.

[125] **Brian Gibbons:** I suspect that there will be a lot in the report that is relevant to the Audit Committee, although I do not know whether there is a day's work in it. Clearly, there will also be policy issues that will flow from it, which it would not be appropriate for the Audit Committee to get involved in. It would not surprise me if there was stuff in there that would be relevant to the Audit Committee as an audit committee. I do not have my diary with me, but I know that I have commitments to go to west Wales, north Wales and so forth on days when we do not have committees and so on. They are usually on Thursdays. I would not like to pull out, because people say that the Assembly is too Cardiff-centric—and we have heard a little of that already today.

[126] **Helen Mary Jones:** Only because I was provoked.

[127] **Brian Gibbons:** I would be unhappy to have to give up going to north Wales or wherever.

[128] **Rhodri Glyn Thomas:** We would not expect you to do that, Minister. You have diary engagements that you must keep, but Helen Mary's suggestion was that we discussed the possibility with your office. I think that there is a feeling that we would like to look at this before Christmas, if at all possible. It is not only on Thursdays, as we also have the option of a Wednesday morning. I know that that may create problems for some committee members, but it may be that they will want to prioritise this particular issue. So, the secretariat will discuss the possibility with your office. If it is impossible, it is impossible, but we will try to find a date that is acceptable.

[129] **Brian Gibbons:** I am just thinking of the date. In the next week to 10 days, the modernisation plan will be going before the ambulance trust. I do not know what the most helpful timing would be to take that. One reason why I am going to north Wales is to meet the chief executive and to have a chat with him about what is proposed. The consultation is finishing, but it has to go to the board.

[130] **Helen Mary Jones:** If we could discuss the report and the modernisation plan together, we could examine the extent to which the modernisation plan meets the concerns that are raised by the report and fit them together. That would seem to make sense.

[131] **Brian Gibbons:** That is the point that I am trying to make. Fitting in a slot before the modernisation plan has even been considered by the trust board might seem a bit early.

[132] **Rhodri Glyn Thomas:** We have an additional problem in the sense that the Audit Committee is looking at this matter on 14 December, which is the last day on which the Assembly is sitting. If we look at it before then, what is our position as regards Standing Orders? Jenny, I am looking towards you on this.

[133] **Jenny Randerson:** Given that the Presiding Officer has said that he has some concern about this, I cannot see why we could not have suspended Standing Orders in this regard. You would have to check with his office.

[134] **Rhodri Glyn Thomas:** Presumably, we can still do that if needs be.

[135] **Jenny Randerson:** We could do it next week.

[136] **Rhodri Glyn Thomas:** How strongly do Members feel about this?

[137] **Helen Mary Jones:** I feel strongly that we need a substantial amount of time to discuss it, given that it comes from here. However, I take the Minister's point that, if we had the inquiry report—and let us not refer to it as an 'audit' report; it was done by the auditor, but it is an inquiry, not an ordinary audit report—and the modernisation plan in front of us, we would be able to look at the extent to which the modernisation plan that the trust agrees meets the concerns that the report identifies. That might be a better way of adding value—not just doing the historical scrutiny of what, if anything, has gone wrong, but also putting our points to the Minister about whether the trust's modernisation plan will deal with the issues that the inquiry report has raised. If that is the case, there might be an argument for letting the Audit Committee get on with it, and coming back to it early in the next session. When is the modernisation plan likely to be finalised?

[138] **Rhodri Glyn Thomas:** It is coming to committee on 14 March.

[139] **Helen Mary Jones:** We cannot wait that long.

[140] **Brian Gibbons:** It is going to the board in the next week to 10 days. The running assumption is that it will approve it, but I do not think that we can take that as an absolute certainty. However, we would be surprised if it did not accept it.

[141] **Helen Mary Jones:** If the board accepts it, would we be able to discuss it earlier in the new year?

[142] **Brian Gibbons:** Sure.

[143] **Rhodri Glyn Thomas:** In that sense, we are looking for a date early in the new year. We cannot do it before the end of this term. I am in no way trying to upstage the Audit Committee on this matter, and nor are any Members; it is just that we feel that this committee has a contribution to make to this discussion. We will look for a date early in the new year—hopefully, in January, but, if not, early in February. We can agree that with the Minister. I take it that the view is that we will hold a special meeting just to discuss those issues in the auditor general's inquiry and the ambulance modernisation plan.

[144] **Helen Mary Jones:** My second point is separate, but it is very important. I am concerned that we are not discussing the 'Fulfilled Lives, Supportive Communities' strategy until March. I realise that the reason for that timing is for us to look at it after the consultation, but my view is that we need to look at it during the consultation and probably again afterwards. I am concerned—and the Minister will acknowledge this—that it makes barely any reference to children's services. This is supposed to be a strategy for social services, but it barely acknowledges children's services. This committee might have a useful input to make at an earlier stage.

[145] **Rhodri Glyn Thomas:** We can accommodate that now, because we can now take the auditor general's inquiry off our agenda on 25 January and include that issue instead, if Members are happy with that.

[146] Gwelaf eich bod yn fodlon, felly, fe dorrwn yn awr a dod yn ôl am 11.15 a.m..

I see that you are happy with that, so we will now adjourn and return at 11.15 a.m..

Gohiriwyd y cyfarfod rhwng 10.57 a.m. a 11.17 a.m.
The meeting adjourned between 10.57 a.m. and 11.17 a.m.

Datblygu Gwasanaethau Gofal Brys
Developing Emergency Care Services

[147] **Rhodri Glyn Thomas:** Un mater sy'n weddill ar yr agenda, ac eithrio'r papurau i'w nodi. A oes gennych rywbeth i'w ychwanegu at y papur sydd wedi'i osod o dan yr eitem hon, Weinidog?

Rhodri Glyn Thomas: Only one item remains on the agenda, apart from papers to note. Do you have anything to add to the paper before us under this item, Minister?

[148] **Brian Gibbons:** The delivering emergency care services strategy started off as part of an overall service redesign of delivering emergency and unscheduled care. The initial document has been out to consultation and there has been a good response. The next stage will be to produce the definitive document and to move towards implementation. Having had another round of discussions with the key stakeholders before implementation moves forward, I think that, in moving forward, we will be looking to develop early adopters to try out some of these schemes in practice and then to work from those early adopters as a means of learning best practice from real-life experience. Having said that, the level of engagement across Wales on this has been very good and virtually all health communities applied to be early adopters because they could see the value of the approach. The difficulty that we had was in deciding who would be the early adopters. The paper is largely self-explanatory and I am happy enough to deal with any questions rather than to continue.

[149] **Rhodri Glyn Thomas:** Yr wyf am fanteisio ar fy sefyllfa fel Cadeirydd i godi un mater, sef y ffaith nad yw'r ddogfen hon yn sôn am wasanaethau sy'n cael eu harwain gan nyrsys. Daeth y Cynulliad i gytundeb o ran cefnogi'r syniad o ganolfannau y gellid cerdded i mewn iddynt, lle mae gwasanaethau wedi'u harwain gan nyrsys. Gwn nad ydynt yn ateb ym mhob sefyllfa ond efallai dylai fod opsiynau felly mewn ardaloedd dinesig fel Caerdydd, Casnewydd ac Abertawe. Mae'n ofid nad yw hynny'n cael ei godi yma. Mae opsiynau hefyd ynglŷn â'n hysbytai cymunedol, yn sicr o ran delio â mân anafiadau a allai fod yn achosion brys, ond nid yw'r gwasanaethau hynny'n cael eu cynnwys yn yr adroddiad hwn ychwaith, os nad wyf wedi'u methu.

Rhodri Glyn Thomas: I will take advantage of my position as Chair to raise one matter, namely the fact that this document does not mention nurse-led services. An agreement was reached in the Assembly to be supportive to the idea of walk-in centres where there are nurse-led services. I know that they are not the answer in every situation but perhaps there should be such options in urban areas such as Cardiff, Newport and Swansea. It is a concern that that is not raised here. There are also options with our community hospitals, certainly in terms of dealing with minor injuries that could be emergencies but those services are not included in this report either, unless I have missed them.

11.20 a.m.

[150] **Brian Gibbons:** I do not agree with that at all, because a tremendous amount of unscheduled care is delivered by nurses, starting off, for example, with NHS Direct. There is specific reference to NHS Direct in the document and that is overwhelmingly a nurse-led service. There is also a reference to minor injury units in the document. Again, in many parts of Wales, they are overwhelmingly nurse led; they are effectively walk-in centres in many communities and they provide nurse-led services. Nurses are making decisions on treating and referring and so on, in the accident and emergency departments. Nurses are very much part of the streaming of patients in accident and emergency departments and nurses respond to that. In busy departments, the nurses, as the lead clinicians, probably deal with 10, 20, or 25 per cent of the workload, depending on where you are and the investment that is put into nurses. I think that that is in the document.

[151] I do not think that the substantive point that you made is correct. I would say that, in moving forward, the role of nurses will be strengthened rather than weakened as the roles are enhanced and we learn from experience. The acute centres and the new GP out-of-hours centres, which will be co-located wherever possible, will be based on multidisciplinary teams. Those teams will involve medical personnel, but they will also involve nurses and maybe others. I think that they will also include social care and so on as they develop and mature. I am not sure that I fully agree with the thesis that you are proposing.

[152] **Rhodri Glyn Thomas:** Yr wyf yn siŵr, Weinidog, y bydd eich sylwadau yn cael eu gwerthfawrogi'n fawr. Fy marn i, a barn rhai pobl eraill, oedd nad oedd hynny'n amlwg yn y ddogfen. Fodd bynnag, gwerthfawrogwn yn fawr eich ymrwymiad i wasanaethau sy'n cael eu cynnig gan nyrsys.

Rhodri Glyn Thomas: I am sure, Minister, that your comments will be greatly appreciated. It was my opinion, and that of some other people, that that was not obvious in the document. However, we greatly appreciate your commitment to services being provided by nurses.

[153] Croesawaf Ann Jones, sy'n eilydd ar ran Karen Sinclair ar gyfer ail hanner y cyfarfod. Croesawaf hefyd Stuart Moncur. Stuart, yr wyf yn meddwl mai dyma'r cyfarfod cyntaf i chi ei fynychu, felly croeso cynnes i chi hefyd. Galwaf ar Helen Mary Jones i ofyn ei chwestiynau.

I welcome Ann Jones, who is substituting on behalf of Karen Sinclair for the second half of the meeting. I also welcome Stuart Moncur. Stuart, I think that this is the first meeting that you have attended, so a warm welcome to you as well. I call on Helen Mary Jones to ask her questions.

[154] **Helen Mary Jones:** First of all, I wish to apologise, Chair, because I will need to leave a little early.

[155] I have a few points to make. One is that the document makes reference to children and that the final document will need to specifically address the needs of children. I stress strongly that that needs to be there and that we need a fully worked-up look at the balance between providing unscheduled care for children as close as possible to home and providing the very special care that they will obviously need for more serious unscheduled events. A paragraph saying that we need to do something particular about children does not tell me what we are going to do or how we are going to do it. I therefore hope that that will be addressed in the final document.

[156] Picking up on Rhodri Glyn Thomas's point, there is a feeling in the Royal College of Nursing that its members have not been as fully consulted as they should have been. I am not proposing to get into a discussion with the Minister about whether or not that is true, but in order to move forward on this strategy, it is obviously important to have the support and full participation of the nursing workforce. I am not, for a moment, trying to get into a discussion about whether or not they were sufficiently consulted; what I am telling you, and I think that other Members know this, is that they do not feel that they were. That perception has to be addressed, whether or not it is a perception that reflects reality. In that context, I think that it is important that they produced a report with 28 detailed recommendations about unscheduled care, and they may have been taken into account in the preparation of this document, but, again, the perception is that they have not been. I hope that you will be able to address that as you move forward.

[157] In presenting the paper, Minister, you mentioned developing good practice models and I just wonder whether the process so far has identified any existing good practice and whether we can build on that. It may be that there is not any good practice. From a patient point of view, I think that the way in which the out-of-hours care is provided at the Prince Philip Hospital in Llanelli, which is predominantly nurse-led now in terms of whom you see

first, is actually working pretty well. It is not the traditional accident and emergency model, but there may be others, so I am just suggesting that we look to see whether there is any existing good practice that could be worked up in the final document, in terms of saying, 'This works well, or this works pretty well, but it could work better if we did that'.

[158] Finally, I stress to the Minister, although I am sure that this does not need to be said, that the final document will need a detailed implementation plan—a road map of how we get from here to there and by when, as well as what has to be done in terms of reusing resources and those sorts of things. I picked up a concern when reading the document that what we have here is basically aspirational. We know where we are from this and we know where we want to go to, but we need to do the detailed work on how we get there. The clearer that can be, then the clearer we can be about the roles for all the professionals and multidisciplinary teams and the more likely we are to get to a much more satisfactory situation. We all know that the current position on unscheduled care is unsatisfactory—the out-of-hours GP service, which is not always available, as the case may be in Powys, for example, is dreadful. So, I support the aspirations here, but we need a lot more detail about how we get there.

[159] **Brian Gibbons:** The exciting element of the document is that it proposes a radically different model, so the first part of is about seeing whether the service shares the vision and the direction of travel. It is fair to say that there has been extremely positive support. The comments made by RCN are fair; it did some detailed work and it was unfortunate that its contribution was not properly acknowledged and referenced in the document. Clearly, one of its big issues is walk-in centres, such as those that they have in England. If that suits certain communities, there is no reason why that cannot be commissioned as part of that document. However, so many parts of Wales are currently dependent on nurse-led walk-in centre facilities, particularly in terms of minor injury units and general practices where patients can go to see the GP or the nurse for an initial consultation and so forth. I did not think that due recognition was given to the substantial role that nurses already play in the health service in Wales in doing that. So, we have a slightly different view on that. However, Stuart has met with the RCN on two or three occasions since the consultation has been winding down to look forward, and I think that those meetings were fairly positive.

[160] There is a lot of very good work being done. As you can see in the graph, the demand for accident and emergency attendances is increasing pretty steadily. In the face of that, the length of time for which people wait in accident and emergency departments, in most places, is now consistently above 90 per cent; the target is 95 per cent, so, clearly, we have not reached that level. However, in the face of a fairly steady consistent year-on-year increase, the actual level of performance in accident and emergency departments is also improving.

[161] It is good that this document is out there and that, as health services redesign how they deliver care, those services are taking note of the principles in this document and are trying to redesign their services on the basis of those principles. There are good examples, such as Bronglais Hospital and how it uses salaried GPs, and not just for its out-of-hours service, because the trust has also employed salaried GPs for working in-hours and they are co-located with the accident and emergency department in Bronglais. That is excellent. Furthermore, I heard yesterday that the use of GPs, side by side, at the fracture clinic in Cardiff has dramatically improved that service and they are able to stream people with primary care problems into the GP side of things. I also know that Neath Port Talbot, on the back of this document, is looking at how it can integrate the GP facility, which is in the same hospital, more closely with the minor injury unit and the acute physicians, so that there is a much bigger and more dynamic front-end of the service. People are employing acute physicians all over the place to allow a more rapid assessment and turnover of patients.

11.30 a.m.

[162] So, there is a fair bit of work going on, but we are still in the foothills of where we want to be. The whole point of the document is to change the service in a more integrated way, but a fair number of things are happening which inform the document. Equally, the document is informing local communities in terms of how they want to refashion their services. I am sure that the ambulance modernisation programme will be informed by the principles in this document, because there is a role in it for paramedics and how they see and assess patients, and to improve their role and referral options, such as bringing people to GP out-of-hours centres, and, in some instances, to diagnose, treat and discharge patients without people going anywhere. There is also the role of community paramedics, which will be delivered by ambulance staff. All of this is in the document, and the ambulance service is also using these ideas as part of its modernisation programme.

[163] **Jenny Randerson:** I do not want to go into the specifics of the nursing issue, but, having read the document, I felt that the general impression was that not enough was being made of the potential role of nurses. You have confirmed my impression this morning, because you said something along the lines of that this, rather than diminishing the role, might increase the role of nursing. We should have a vision that says that we will increase the role of nurses to make a more flexible and efficient service.

[164] On another nurse-related issue, there are references to the expanded role of specialist nurses, which is not referred to in the document—at least I could not see it.

[165] To turn to different issues, I originally thought that the document would also include the fire and ambulance services. I though that it would have links with those services.

[166] **Brian Gibbons:** No.

[167] **Jenny Randerson:** So, you are not going to develop links in the future across emergency services?

[168] **Rhodri Glyn Thomas:** Do you want to come back on this, Minister?

[169] **Brian Gibbons:** I saw the Members' research service questions, but at some stage someone got the wrong end of the stick on this issue. This is essentially about health and social care reconfiguration in terms of unscheduled care, and it is the focus of what the document is about. There are areas where it will interface with the ambulance and fire services, such as on the co-location of ambulances in a fire station and the use of ambulance personnel as first responders. There is an interface, and there is a bigger agenda item as to whether or not there should be trilocated communication centres. So, there is an interface with those services that must be addressed as time goes on. However, it was never envisaged that the document would be a major statement as to how the fire service and the police service would be all wrapped up together. It was never the intention, and I do not know how that impression got out.

[170] **Jenny Randerson:** I was interested in the issue from the point of view of the co-location of call services, and so on, as a potential. However, I want to concentrate on the issue of the telephone contact—the triaging model—and so on. I have received comments from an out-of-hours service that works across the border about the problems associated with the system in England. It brought to mind the dreaded oxygen contract. How will you build up the capacity in NHS Direct to deal with the number of queries that it will have to co-ordinate? The issue is that we cannot have a system that fails. It was bad enough when the oxygen system failed for months on end, but if any new system failed in the first few weeks it would be disastrous. Do you have a proposal to roll out the new system gradually, perhaps with a pilot project?

[171] **Brian Gibbons:** I will deal a little with the NHS Direct issue. Some of the Shropdoc stuff was a useful contribution to the discussion, so I will not knock that. We appreciate the time and effort that it put into making that submission, and it was a fairly substantial submission, which Stuart and his colleagues have taken seriously. The only thing that I will say is that I got the impression that a lot of it was based on Shropdoc in England and on how NHS Direct worked in England. NHS Direct in Wales is not NHS Direct in England, although I am not saying that some concerns were not raised about Wales. A lot of the criticism was about how NHS Direct was operating in England, but other points were raised about the use of software and so forth, and Stuart may be able to add to that. He can also give some information on how the early adopter will be involved and how it will be gradually rolled out.

[172] **Mr Moncur:** First, on the point of Shropdoc, its representatives contacted us and asked us whether they could comment, which we encouraged them to do, because it is important. The Minister's point is quite right, in that there is quite a difference in the performance of NHS Direct in England and in Wales, with the Welsh performance being considerably better. However, Shropdoc raised some valid points, particularly about the software systems. One thing that we are doing at the moment is looking at the software systems that are used. You may be aware that there are a couple of different sorts of software systems being used by NHS Direct in England and in Wales, and there is a different system used by most GP out-of-hours providers. At the moment, we are talking to NHS Direct, the ambulance service and out-of-hours providers about what the best model might be. It is possible that the current system that NHS Direct is using may not be the best one to deliver this vision as it is currently described.

[173] In terms of the impact on NHS Direct and its capacity, one thing that is immensely frustrating for NHS Direct staff is that if someone rings up with a particular problem, the software system takes them through a very long and continuous system. One thing that these experienced clinical professionals come across quite regularly is that they find that individuals will need to be seen by a clinician at some point, but the whole process that they work within takes them through what might be a 20-minute discussion with a patient. At the end of it they are left having to say, 'It is probably okay, but you will need to see somebody'. However, with this model, as soon as they identify that someone needs to be seen, it lets them make an appointment. So, huge chunks are taken out of the process. One thing that we have reflected on all the way through this is the patient's experience, and I would be the first to say that it must be immensely frustrating for patients to go through that whole process only to be told that they need to see a GP or someone in an accident and emergency department.

[174] There are lots of opportunities to streamline the process, which can make big differences to capacity. In terms of early adopters, which is what we are calling the pilot process, you are right—there are some real issues about testing how well it works. We are proposing to go with three early adopter sites, which will be in each of the three health regions of Wales. We have asked for submissions from the service, from health communities, and all, bar two, have submitted bids to be early adopters, which is quite a good reflection of the fact that they recognise the vision as being something that they want to aspire to. In a number of areas, it feels a little like pushing at a semi-open door. One thing that we will be testing is the capacity of these organisations to deliver. As the Minister said, while this may be common sense, it is quite a radical step in some ways. We need to ensure that we get the capacity of these organisations right to deliver these services. So, we will be taking an early adopter approach, and then a phased roll-out across Wales.

11.40 a.m.

[175] **Jonathan Morgan:** On the Royal College of Nursing, while the Minister accepts the criticism, the royal college has never been backwards in coming forward, so it is more than capable of putting its views to the fore. However, I would support as much reference as

possible to the excellent work that is done by a variety of health professionals, not just nurses. We must recognise the expertise in delivering a variety of care, including unscheduled care.

[176] The key factor for me is ensuring that we have as much flexibility as possible. A one-size-fits-all approach will not work, and it will be about the information that we get from the various health communities about what works best for them. Whether walk-in centres—or however you will term them—are co-located with current accident and emergency departments, or whether they are situated in large town centres, will depend purely on the area's demographics and geography. However, I would support any improvement in capacity by using the sort of model that has been pioneered in England. I remind you that the Assembly voted in principle—and you supported in principle—the notion of nurse-led walk-in centres. The document notes that, in some areas of Wales, that may be more appropriate than other schemes that you may be examining.

[177] The out-of-hours issue is crucial to this. I am pleased that this has already been picked up, but I am not convinced by the current relationship between the out-of-hours service and accident and emergency. I have encountered too many constituency cases where people have done what they should have done, and gone to the out-of-hours service, only to be told, 'We cannot do much; you must go to accident and emergency'. We often criticise patients for wrongly going to accident and emergency departments, where they should have accessed primary care in the first place, but, often, those people who access primary care are told, 'We cannot do anything—go three or four miles up the road to the Heath hospital'.

[178] Sadly, I have encountered several cases where patient experience of the out-of-hours service has not been up to scratch. Rather stupid questions are being asked of parents, when it is clear that their child is not bleeding, and does not have a chest complaint, but merely has a high temperature and a rash. However, because of the time spent going through the list of questions, parents become agitated with how the out-of-hours service operates, particularly in Cardiff. If we can start getting that right, then it will probably build a healthier relationship between what it does and what the accident and emergency services are meant to achieve.

[179] I know that, in certain parts of Wales—and Cardiff is no exception—some trusts are looking at how accident and emergency services are delivered alongside elective services. My view is that, where possible, the two should be separate. We know that accident and emergency services have had an effect on the ability to deliver elective care, and that pressure is put on beds—sometimes beds are lost to the elective services, and patients have their operations cancelled. Therefore, whatever we can do to divide the two makes perfect sense; having a division, as far as is practically possible, between elective care and accident and emergency care makes perfect sense.

[180] You mentioned NHS Direct, and said that we had a better system in Wales, and that what we are achieving in Wales is better than what is achieved in England. I would like to see any qualitative work on that, because I have been concerned in recent years about the impact of NHS Direct—whether it is a valuable service and whether it does the job properly. Any data that we have to show what the workings of NHS Direct are, and how successful it is, or otherwise, would be useful when considering the consultation to this document.

[181] Those are all my points for the time being.

[182] **Brian Gibbons:** The point about other professionals being involved is true. For example, at the University Hospital of Wales, the physiotherapists are in the department and take more or less direct referrals—or certainly take referrals quickly—in the care pathway, from a range of people. Again, we need to remember the pharmacists in this. Some 700 plus high-street pharmacists have independent prescribing. With the roll-out of minor illness schemes, the role of pharmacists will increase, and pharmacists are becoming integrated into

NHSnet—our IT system. Therefore, pharmacists will certainly have a role to play as well in a way that has not been anything like as common as previously.

[183] The whole point of the system is to try to create a single, consistent point of entry, so that, when you ring up, no matter how you get into the system, you will have a single, common, consistent and quality-assured initial point of contact with the service. When you physically use the service, you will be appropriately triaged. You may go to the GP out-of-hours system with community nurses, doctors and pharmacists or whatever, or to the minor illness scheme or to an extended-role nurse practitioner or, if you have a serious injury, instead of having to be diverted through another scheme, you will be put straight into the serious injury stream. That is one of the strengths of trying to trilocate the services and having a good front-end triage or filter, or whatever you want to call it: when you go into the system, they are able to say to you, 'Right, you've got a GP problem: go there', or, 'You've got a fracture: go there', or if you have another problem, you will have a quick assessment with a physiotherapist or whatever. That is the model that we are trying to deliver.

[184] **Jonathan Morgan:** I am grateful for that response. In terms of this being a strategy, obviously, it will not be delivered overnight, and, clearly, there will be budgetary implications for what you want to achieve, particularly as you will be looking to expand and will, effectively, be expanding the capacity of emergency care services to cope with the demand. What will the impact be on the various professions? I assume that you cannot just take nurses and other professionals out of one particular unit and stick them somewhere else, but that you will have to look at recruitment to ensure that we have sufficient people to cover what is already being provided and to provide the services and additional capacity that you are looking to obtain. Has any work been done yet to assess the likely impact on the workforce in terms of workforce numbers and what is the likelihood of a guide as to what we will be requiring from a budget perspective?

[185] **Brian Gibbons:** Stuart may want to comment, but, in general, I approach this from the point of view that it is making better use of the people that we have in the system at the moment. In that sense, it is about making the present system work better, rather than bringing in large numbers of new people. A fair amount of people are involved in delivering unscheduled care, but, as Stuart has said already, from the patient point of view, it is bewilderingly complex and the patient experience and response are the worse for that. The key starting-off point of the delivering emergency care services project was to bring consistency and simplicity to the system. It is, essentially, about making the people who are delivering the service at the moment work more coherently, rather than saying that we need to recruit lots of people into the system. Stuart, can you say how far you think that extra capacity is needed?

[186] **Mr Moncur:** There are a couple of issues there. First, as part of the draft implementation plan, we have a work stream that is looking at manpower planning. In the consultation exercise, we asked people to feed back to us on where they were in terms of delivering this vision. As the Minister said before, many people are doing things that are completely consistent with this document, so we have had that response.

[187] The implementation and manpower issues are quite complicated. In some areas, the changes that are needed are not that great. To give you a practical example, in the Princess of Wales Hospital, the nurses working in the accident and emergency department have been trained—it was a relatively short course, which took a matter of weeks—and upskilled so that they can treat particular conditions that they were regularly facing. That has made a huge difference to the way that the department works. So, some of the differences are quite small. With regard to the other changes and differences that we would expect to see, some of them are happening already.

11.50 a.m.

[188] There is the role of advanced practitioners in the ambulance service, for example. There are many people who are trained to do things, but the problem is that we have a service that does not really allow them to discharge services to the best of their ability—I think that that is the best way I can put it. Some of it, therefore, is about ensuring that we let people do what they are capable of doing by changing the service to fit that.

[189] There are likely be some one-off costs, mainly around ensuring that we have the right skills in the right place. As the Minister said, the main focus of this is on refocusing the service. The more likely cost will probably be in the front-end services, which may be around capital rather than revenue. We have a clear process for people to identify capital requirements.

[190] **Ann Jones:** First, thanks for the invitation to come back. It is like old times—I really enjoyed my time on the Health and Social Services Committee.

[191] I have looked at the paper. I am sorry if I am about to ask a question that has already been asked, or if you have discussed this matter previously. However, with regard to the IT interface, Jonathan mentioned NHS Direct and the patient experience facility, which I have used, so I can speak from personal experience. When I tried to use NHS Direct Wales on Friday night to avoid going to the accident and emergency department, I kept being told, 'Oh, you should go to A&E', and 'If you're worried, go to A&E', but I was trying to avoid going to the accident and emergency department, because I just wanted a bit of advice. It is about the interface, because you mentioned going through the whole long process.

[192] Jonathan referred to a case of a child with a high temperature, and the questions about whether the child is bleeding and so on—it is about short-cutting some of the pages out of that. My experience of NHS Direct was that I went through the whole process of triage on the telephone, which took some 10 minutes. Somebody else called me back and I went through the whole triage again for another 10 minutes. It is those kinds of issues that we need to address. Had I gone to the accident and emergency department, I would, no doubt, have gone through the whole triage there. We need to move the IT very quickly so that, if your first point of call is via NHS Direct or via an out-of-hours GP system, and then you do end up at another service, all those details will have arrived before or at the same time as you do, so that you are not put through that experience of having answer the same questions. You may have discussed this, but I am keen to see action on this issue. You mentioned capital; would that be part of the capital outlay that you would be looking at?

[193] **Mr Moncur:** The points that you make are very valid. In terms of NHS Direct, we have started to change the way in which it operates so that those patient groups that use out-of-hours services, as opposed to the 0845 service, go straight through to a nurse rather than through a call-handling route, because those patients tend to be more anxious than those people who are using the general information service. That looks to be working well at the moment. It is running in two areas, and we would like to roll it out to a third if it develops.

[194] I would be the first to recognise your point about the danger of having to repeatedly give the same information to organisations. That is an issue that we are looking at in this; we have a work stream looking at information and IT, but that has very much involved the work that Informing Healthcare is doing. To give you a practical example, one of the things that we have been doing with Informing Healthcare is to use the GP out-of-hours services in Gwent to access GP records, so that, when the out-of-hours service goes to see a patient, the GPs can get the primary care information out of the practice system, as opposed to them simply having to rely on what the patient tells them: they can have a good look at the medical records, which are sat back in the practice.

[195] There are other initiatives are going on. There is a good example in Pembrokeshire, where the out-of-hours service can access the hospital pad system so that, if the patient has recently been discharged, it is relatively easy for the doctor to see exactly what the patient had when in hospital. The technical side of these links is not that complicated to arrange. We have work ongoing to ensure that that can happen, and, again, some of this will be tested out through the early doctor route to make sure that these links are sound and robust, because, if they do not work, it will be even more frustrating than the current service. We have to get this right.

[196] **Rhodri Glyn Thomas:** Oes unrhyw sylwadau neu gwestiynau eraill, o gwbl? Gwelaf nad oes. Mae papurau i'w nodi, ond heblaw am hynny, diolch ichi am eich cydweithrediad. Yr ydym wedi gorffen ryw hanner awr yn gynnar.

Rhodri Glyn Thomas: Are there any other comments or questions? I see that there are not. There are papers to be noted, but apart from that, thank you for your co-operation. We have finished about half an hour early.

Daeth y cyfarfod i ben am 11.55 a.m.
The meeting ended at 11.55 a.m.