



**Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol**

**The National Assembly for Wales
The Health and Social Services Committee**

**Dydd Mercher, 13 Rhagfyr 2006
Wednesday, 13 December 2006**

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

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

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

Swyddogion yn bresennol: Neil Buffin, Adran Iechyd a Gwasanaethau Cymdeithasol; Claire Cullen, Adran Iechyd a Gwasanaethau Cymdeithasol; Donna Davies, Adran Iechyd a Gwasanaethau Cymdeithasol; Susan Elsmore, Adran Iechyd a Gwasanaethau Cymdeithasol; Keith Ingham, Adran Iechyd a Gwasanaethau Cymdeithasol; Dr Tony Jewell, y Prif Swyddog Meddygol; Peter Jones, Ymgynghorydd Cyfreithiol i Swyddfa'r Llywydd; Ann Lloyd, Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol; Paul Parker, Adran Iechyd a Gwasanaethau Cymdeithasol; Dr David Salter, Uwch Swyddog Meddygol; Carys Thomas, Adran Iechyd a Gwasanaethau Cymdeithasol.

Eraill yn bresennol: Jonathan Davies, Conffederasiwn GIG Cymru; Dr Andrew Fowell, Cadeirydd, y Grŵp Cyfeirio Arbenigol; Mike Ponton, Cyfarwyddwr, Conffederasiwn GIG Cymru.

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

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

Officials in attendance: Neil Buffin, Health and Social Services Department; Claire Cullen, Health and Social Services Department; Donna Davies, Health and Social Services Department; Susan Elsmore, Health and Social Services Department; Keith Ingham, Health and Social Services Department; Dr Tony Jewell, the Chief Medical Officer; Peter Jones, Legal Adviser to the Presiding Office; Ann Lloyd, Head, Health and Social Services Department; Paul Parker, Health and Social Services Department; Dr David Salter, Senior Medical Officer; Carys Thomas, Health and Social Services Department.

Others in attendance: Jonathan Davies, Welsh NHS Confederation; Dr Andrew Fowell, Chair, Expert Reference Group; Mike Ponton, Director, Welsh NHS Confederation.

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

*Dechreuodd y cyfarfod am 9.00 a.m.
The meeting began at 9.00 a.m.*

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

[1] **Rhodri Glyn Thomas:** Bore da. Mae'n 9 a.m. ac felly dechreuwn. Mae Lynne Neagle a Karen Sinclair wedi ymddiheuro y byddant yn hwyr yn cyrraedd y bore yma. Gwnaf y datganiadau arferol. Os oes gan unrhyw un unrhyw offer electronig, dylent sicrhau eu bod wedi eu troi i ffwrdd—nid yw'n ddigon eu gadael ar dawel. Os bydd angen i ni symud o'r ystafell hon, dilynwch gyfarwyddiadau'r tywysyddion os gwelwch yn dda. A oes unrhyw fuddiannau i'w

Rhodri Glyn Thomas: Good morning. It is 9 a.m., so we will begin. Lynne Neagle and Karen Sinclair have sent their apologies that they will be late arriving this morning. I will make the usual announcements. If you have any electronic equipment, you should ensure that they are switched off—it is not enough for them to be switched to silent mode. If we need to leave this room, please follow the ushers' instructions. Are there any declarations of interest? I see that there are

datgan? Gwelaf nad oes.

not.

9.01 a.m.

Is-ddeddfwriaeth: Deddf Galluedd Meddyliol 2005
Secondary Legislation: Mental Capacity Act 2005

[2] **Rhodri Glyn Thomas:** Mae nifer o faterion i'w trafod o ran is-ddeddfwriaeth. Mae'r cyntaf ar Ddeddf Galluedd Meddyliol 2005, ac mae Helen Mary Jones yn dymuno codi pwynt o eglurhad.

Rhodri Glyn Thomas: There are many issues to be discussed in terms of secondary legislation. The first is on the Mental Capacity Act 2005, and Helen Mary Jones wishes to raise a point of clarification.

[3] **Helen Mary Jones:** Does the Government have any intention to make provision, under section 41, to offer an independent advocate even to those individuals who may have families or carers available?

[4] **The Minister for Health and Social Services (Brian Gibbons):** The main provision under this legislation is made if the person is at risk from violence or abuse, particularly in an adult situation. In those circumstances, even though there may be relatives to hand or available, there is discretion for the use of independent mental capacity advocates.

[5] **Helen Mary Jones:** The concern has been raised in a number of contexts—with vulnerable adults and children—that the interests of families and carers do not always coincide with what is best for the service user, even though they may have the best of intentions. Of course, in the kind of situations that we are talking about here, it is possible that the risk of abuse may arise from within the family. Will you say a bit more about who will have the discretion and how it might be exercised? If you have a situation where you have a family member who is articulate and able to use his or her voice and a service user who is not, my concern is where that discretion will kick in and whose discretion it will be.

[6] **Brian Gibbons:** By definition, the potential victims will not be able to speak up for themselves because if they were able to do so, they would not be in that situation. It will be at the discretion of the local health board or the local authority. There are two situations in which it will be mandatory to have the advocate in place and two situations in which there will be discretion, one of which is a review of a change of accommodation and so on. However, this is the second situation. The answer is that we will be relying on the professionalism of the local health board or the local authority to make that decision. I think that whoever is involved, be it a social worker or whoever, as in many of these situations, we are dependent on the professional judgment of the lead worker.

[7] **Helen Mary Jones:** That is helpful, Minister, and obviously that is a judgment on which we can normally rely. Am I right in understanding that there will be a specific code of practice on how these guidelines will be used? In that context, can you clarify whether there will be a separate code for Wales or whether it will be a joint code, and whether it will allow for the provision of advocacy in the language of choice?

[8] **Brian Gibbons:** That goes without saying. In Wales, Welsh would obviously be a big part of it, but in other parts of the United Kingdom, or in England as compared with Wales, the choices would be different.

[9] **Helen Mary Jones:** I would just say that there are occasions, sometimes, Minister, where things that go without saying go without doing as well, so it was a point worth raising.

9.05 a.m.

Is-ddeddfwriaeth: Cyfarwyddiadau Gwasanaethau Deintyddol Byrddau Iechyd Lleol 2007

Secondary Legislation: The Local Health Board Dental Services Directions 2007

[10] **Rhodri Glyn Thomas:** Nid oes Rhodri Glyn Thomas: No points of clarification or amendments have been raised, so these directions are to note only.

9.05 a.m.

Is-ddeddfwriaeth: Rheoliadau Lleoli Plant (Cymru) 2007, a Rheoliadau Cartrefi Plant (Cymru) (Gwelliannau Amrwyiol) 2007

Secondary Legislation: The Placement of Children (Wales) Regulations 2007, and the Children's Homes (Wales) (Miscellaneous Amendments) Regulations 2007

[11] **Rhodri Glyn Thomas:** Mae tri Rhodri Glyn Thomas: Three points of clarification have been raised by Helen Mary Jones on this subordinate legislation.

[12] **Helen Mary Jones:** Do you want to do all three at once, or take them one at a time?

[13] **Rhodri Glyn Thomas:** Awn un wrth Rhodri Glyn Thomas: We will take them one by one.

[14] **Helen Mary Jones:** The first one is whether the Minister can detail whether any additional funding will accompany these measures.

[15] **Brian Gibbons:** If we get a budget—[*Laughter.*]

[16] **Helen Mary Jones:** I suspect that you will get one eventually, Minister.

[17] **Brian Gibbons:** There is £6.1 million—[*Interruption.*] There may be no budget if some people have their way and then we will be in a worse situation than ever.

[18] **Rhodri Glyn Thomas:** Gellir cadw'r Rhodri Glyn Thomas: Those kinds of comments can be kept for this afternoon's Plenary, Minister. We will focus on the business of this committee.

[19] **Brian Gibbons:** There is £6.1 million allocated for the implementation of this range of services. It is a very wide-ranging change to the way that vulnerable children will be managed in Wales and it will represent a real gear change or step change in the way that all of this is managed, making it much more proactive. The allocation of £6 million, hopefully, will be in addition to the money that is already in the system.

[20] **Helen Mary Jones:** I am pleased to hear that. To go on to my second point, in terms of that extra funding, or in other parts of the budget, can you detail any plans for an uplift for child and adolescent mental health services? As you know, it has been a big concern for the committee and it is obviously relevant to the implementation of these regulations.

[21] **Brian Gibbons:** We need to acknowledge the progress that has been made in child and adolescent mental health services to date. For example, there is the fact that 25 to 30

primary care workers have been trained and so forth. The capital budget is moving ahead to provide resources for tier 3 and tier 4. More specifically, in areas such as speech and language therapy, waiting times are coming down as part of the therapy and diagnostics waiting times targets, and, as part of the overall waiting times strategy, approximately £2 million is being allocated to reduce waiting times further. Having said that, most of the waiting times targets for CAMHS are being more or less delivered now. Certainly, Health Commission Wales has delivered. Similarly, they are not hard and fast targets, but the indicative targets from the youth offending team are more or less being met as well, so, hopefully, the extra £2 million will help to build on that improvement. The review of CAMHS will also give us the type of extra information and steer that will mean that, if further work is needed, we will have an evidence base for it.

[22] **Helen Mary Jones:** As a supplementary to that, focusing on the mental health of looked-after children, while we would acknowledge that the waiting times for CAMHS are going down, some of us are concerned about young people who are not being picked up, especially young people with early presenting symptoms and low levels of distress. My concern is about some behaviours that would be treated if a child was living with a family. Just because children looked after, they are sometimes treated as if a certain level of distress can be expected from them, but I do not think that any of us would want to see that. What systems do you have in place to monitor nationally the mental health of looked-after children and will these regulations set in place a framework so that we can focus more on preventative and early interventions, specifically for looked-after children?

[23] **Brian Gibbons:** If you look at these regulations, there are a number of areas where there should be proactive work. If children are in children's homes, they will have a link worker, who will have a special responsibility to liaise with other agencies. From the education point of view, personal education plans will have to be developed by a named worker who will be working with the looked-after child. Equally, from the health service point of view, there will be a designated nurse in the local health boards and the local authorities. There will be designated medical officers who will have an overview of what is going on.

9.10 a.m.

[24] As I said, these are substantial changes in the way that services for looked-after children will be delivered in Wales, and we cannot underestimate the shift towards proactive work in this. Moving on to the education aspect, the work that is going on in counselling in relation to bullying, for example, and other types of activity, will again underpin this. As named individuals will be responsible for the various elements of the child's development, who will, hopefully, have a good personal bond with that child or young person, this sort of proactive approach should pick these things up. We know that an awful lot of children come into care because they have been damaged; they will be in distress and they will have had bad life experiences and, sadly, this is the point at which the services start interacting with them. So, it is a difficult area, but I genuinely believe that this represents a step change in what we are doing.

[25] **Helen Mary Jones:** When children and young people come into care, they are, of course, often distressed, but my point was that those levels of distress would not be treated as normal, accepted and just lived with in the case of children who live with their families. In the past, perhaps we have tended to assume that it is okay for people to be in that state. I think that you are right that if these joint arrangements work effectively, they will make a big difference in picking things up and enabling people to get the services that they need sooner.

[26] That brings me to my third point of clarification, which is about joint working, as you know. This will be a step change if it works, but it does ask for a lot of co-operation and joint

working. Can you tell us how these regulations address the different commissioning arrangements that exist across the authorities that will be responsible for the different actions that need to be taken?

[27] **Brian Gibbons:** There is one point that I should have made before we ended the last bit: for children under five years of age, there will be a twice-yearly health check and an annual health check for those aged over five. Even if everything is going smoothly, as we hope that it will, there will still be proactive checks for the under-fives and the over-fives.

[28] From the local authority point of view, considerable progress is being made in local authorities in different parts of Wales, as part of 'Making the Connections' and the Beecham approach, to start joint working, particularly on the children's commissioning resource. I think that the preparatory work is now more or less complete. The database is more or less complete. The next stage is for that to be used as a practical tool to help with placements. If a decision has been taken to place a child out of county, a panel has to be brought together that involves all the serious players. That does not just mean people from social services, for example, because people from health and so on also have to be proactively involved, either in making those decisions in advance or, if decisions are made in an emergency situation, there are strict timescales that these panels must meet and they must proactively plan for what these children need. Part of the whole system that will underpin this is the fact that there will be nominated people in health and education and so on. Ann was just saying to me that there is guidance underpinning this, because this is just the tip of the iceberg. I know that there is a lot of paper there, but there is a whole lot of guidance and good practice behind this. As I say, I think that this will be a real change and I know that a lot of hard work has gone into getting this done.

[29] **Mr Ingham:** On that final point, it is worth picking up that the significance of this arrangement is the panel arrangement and the fact that you have the involvement of all of the agencies. While a number of out-of-area placements are currently bipartite or tripartite funded, there is not a continuing responsibility once the child is out of the area, certainly not in terms of the health services. The difference here is that they will have that continuing responsibility. So, not only will they be providing funding, but they also have to keep in touch and know what is happening with that child.

[30] **Brian Gibbons:** That is right. One of the big problems, particularly on the health side, was deciding who would pay for the services. Now, for secondary services, the authority in the area from which the child originated is the responsible authority rather than that where the child is resident. That has been the source of considerable argument and a delay in service provision. However, this legislation makes it really clear. Keith's point was good. This means that the originating local health board or local authority has to continue to liaise with the area in which the child is resident and help to maintain those links with the area from which the child has come.

9.16 a.m.

Is-ddeddfwriaeth: Cyfarwyddiadau i Fyrddau Iechyd Lleol ar Ddatganiad o Hawliau Ariannol (Diwygio) (Rhif 3) 2006, a Chyfarwyddiadau i Fyrddau Iechyd Lleol (Rhaglen Brechu Plant) 2006
Secondary Legislation: the Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2006 and the Local Health Board (Childhood Immunisation Programme) Directions 2006

[31] **Rhodri Glyn Thomas:** Mae un **Rhodri Glyn Thomas:** Karen Sinclair has a pwynt o eglurhad, gan Karen Sinclair. point of clarification.

[32] **Karen Sinclair:** I would like clarification on the arrangements for the immunisation. Paragraph 2 of the Local Health Board (Childhood Immunisation Programme) Directions 2006 deals with the arrangement of the administration of the recommended vaccinations. It states that:

‘A local health board will ensure that arrangements are in place in its area to provide, so far as reasonably possible, that all children in the categories identified...’

[33] and so on. Do you think that ‘reasonable’ is a strong enough word? I am thinking in particular of hard-to-target families. What is ‘reasonably possible’ could differ from one area to another. It gives a certain amount of latitude. I would like some sort of exploration of how we can ensure that that is as tight as it can possibly be.

[34] **Brian Gibbons:** I suppose that ‘reasonable’ is always put into these things to allow for some proportionality in terms of how you respond to them. However, there are a number of safeguards and a number of tiers in this. Wherever possible, you want people to be registered with their general practitioner. The way that these payments are made, whether it is through the target payments or the fee per item, which is the case in this particular instance, means that there is a financial incentive for the practice to deliver this service. Equally, all children should have designated health visitors so that if, for whatever reason, the child is not registered, the health visitor at least will have some responsibility. In many parts of Wales, health visitors are very proactive. If you take an area such as Wrexham, where the local health board is very proactive—and I was at the Travellers’ site in Wrexham six or nine months ago—there was a bus that went to the Travellers’ site and a range of health workers and support workers went out to that site to help to promote the health and wellbeing of the Travellers there.

[35] The National Public Health Service will be monitoring the uptake of the vaccinations at a reasonably detailed level. If certain geographical areas are noted as having a relatively low uptake, then extra efforts can be made. We know that the Swansea bay area, the *South Wales Evening Post* area, has always had a low take-up of the measles, mumps and rubella vaccination and it has taken a considerable number of years to reverse the adverse publicity about MMR immunisation in the *South Wales Evening Post*. I think that we are only just about getting back to being close to the national average on the take-up of MMR immunisation in Wales. However, in such an area where the statistics show that there is a low uptake, we must be proactive and I think that the health agencies have been.

9.20 a.m.

[36] **Karen Sinclair:** I take on board what you are saying, but what would the time lag be between the deficit happening and the statistical evidence of a gap being published? This needs to be done at a certain point in a child’s life. If that is missed, our statistics showing that it was missed is not good enough. I also worry about the children of disaffected parents. There is a group there that may be hard to reach. This particular vaccination is part of a package of vaccinations. You will have one sort of vaccine at so many weeks and then another sort after a few weeks, and so, if one is missed, there is a real problem.

[37] **Brian Gibbons:** Yes, but there is a printout of all the children who have it every month. So, once you register with the health service, you are on the database and, every month, the list of children who are due to have their immunisations is automatically run out, and that is generally made available to the practice and/or the health visitor. So, everyone should have a list of who has been immunised. The health professional is meant to tick off on the sheet when a person has turned up for vaccination, and so, if a person defaults, the name goes back into the computer system and is re-presented. You would then expect the health

visitor, particularly, to tackle it, but practice nurses in general practices are increasingly being used. I think that there are situations in which health visitors and practice nurses go out to people's homes proactively and present themselves, explain the benefits of immunisation, and offer to administer the vaccine in people's homes. However, having said that, what is the level of immunisation? I think that it is around 91 per cent or 92 per cent.

[38] **Dr Jewell:** As the Minister says, our main problem is MMR immunisation in mid and west Wales, where take-up is relatively poor at 82 per cent. On all the other immunisations, Wales is doing very well. The target tends to be to try to achieve more than 95 per cent to get good community immunisation, and we are achieving that across Wales. Even in disadvantaged areas such as Merthyr and Blaina, the level is at 96 per cent or 97 per cent. In fact, the picture for childhood immunisation is very good in Wales. What you can see here is the pneumococcal vaccine, which is new, and so we do not have the information on that as yet, but the existing immunisation rates are very good, apart from the MMR, which we are working on. That is increasing year on year, getting up to the level that we want it to be at, namely back to the 95 per cent. So, the picture is generally good and there is very active follow-up in GP practices for those families who need to be followed up.

[39] **Karen Sinclair:** 'Reasonably possible' will mean the same thing to every local health board, will it? That has worried me, because provision will largely depend on how that phrase is interpreted.

[40] **Dr Jewell:** I would suggest that we circulate the data from each LHB because it is all presented by each local health board. We could send that around because it is generally a good-news story.

[41] **Rhodri Glyn Thomas:** Byddai **Rhodri Glyn Thomas:** That would be very hynny'n ddefnyddiol iawn. useful.

9.25 a.m.

Adolygiad y Pwyllgor o Wasanaethau Canser Committee Review of Cancer Services

[42] **Rhodri Glyn Thomas:** Symudwn yn awr at eitem 6, sef ein hadolygiad o wasanaethau canser. Gwahoddaf Mike Ponton a Jonathan Davies at y bwrdd, ac Andy Fowell, sef cadeirydd ein grŵp arbenigol. Yr wyf yn ymwybodol bod aelodau o'r grŵp arbenigol gyda ni heddiw, felly nodaf ein gwerthfawrogiad o'r gwaith yr ydych yn ei wneud i'n cyfarwyddo yn y maes hwn, sy'n ein galluogi i sicrhau y bydd yr adroddiad hwn yn cael ei gyflwyno yn fuan yn y flwyddyn newydd. Mae'r amserlen yn dynn, ac yr ydym yn ddibynnol iawn ar eich arbenigrwydd a'ch parodrwydd i wasanaethu'r pwyllgor. Yr ydym yn ddiolchgar am hynny. Mike, Jonathan ac Andy, a wnewch chi ddod at y bwrdd?

Rhodri Glyn Thomas: We will now move on to item 6, namely the committee's review of cancer services. I invite Mike Ponton and Jonathan Davies to come to the table, along with Andy Fowell, who is the chair of our expert reference group. I am aware that members of that group are present today, and so I wish to record our appreciation of the work that you are doing to instruct in this area, which enables us to ensure that this report will be presented early in the new year. It is a very tight timescale, and we are heavily reliant on your expertise and your willingness to serve this committee. We are very grateful for that. Mike, Jonathan and Andy, could you please come to the table?

[43] Mae papur wedi ei gyflwyno ar gomisiynu gwasanaethau gan y A paper has been submitted on the commissioning of services by the

confederasiwn. Mike, a ydych am ddweud unrhyw beth cyn inni symud at gwestiynau a sylwadau, neu a ydych yn hapus inni droi yn syth at aelodau'r pwyllgor?

confederation. Mike, do you wish to say anything before we move to questions and comments? Or are you content for us to turn immediately to the committee members?

[44] **Mr Ponton:** I am happy for you to turn to questions immediately. I hope that our work has been useful, and you will probably want to ask us about that.

[45] **Helen Mary Jones:** I will start with the first paper, or at least the first in my file, which is 'Commissioning—can we get it right?'. In the conclusions and the way ahead on page 16, you talk about the idea of LHBS as sovereign local commissioners and of pooling some of that sovereignty. You also say that the notion of sovereign local commissioning is not without problems. Can you say more about what those problems might be?

[46] **Rhodri Glyn Thomas:** Cyn i Mike ymateb, a oes cwestiynau atodol ar y pwynt penodol hwnnw o ran comisiynu? Gwelaf nad oes.

Rhodri Glyn Thomas: Before Mike responds, are there any supplementary questions on that specific point of commissioning? I see that there are not.

[47] **Mr Ponton:** Sovereignty is very interesting, and it reflects the role of local health boards, as, essentially, they have two clear responsibilities: assessing the need of local populations and having a particular interest in improving and protecting health in partnership with local government. Part of the assessment of need is also about making sure that services are in place for the local population. Cancer services is one area in which you can see that, because local health boards cannot, because of critical mass, commission the types of services that their population will need, and the same is true of many other types of specialised services. So, the whole direction of this paper is that there is no right place to do commissioning, but you must be clear about what types of services need to be commissioned where. With all the research that has taken place in the UK and further afield, we have seen that you must decide on the right level and the right critical mass, and you must decide what that means in relating it back to the local population.

[48] **Helen Mary Jones:** To pick up on the point about there not being any right levels of commissioning, from the point of view of this committee, that is grim news indeed. One thing that we are hoping to do, specifically in terms of cancer services, is come up with some recommendations for the Government on the right level of commissioning for those services, and, of course, I would not argue that there are not other more appropriate levels of commissioning for other services.

[49] Both of your papers put a great deal of emphasis on the concept of partnerships. Members of the committee will be aware that I am a little worried about partnerships, because the problem with them is that, unless you are very clear, you can lose the focus on whose responsibility it is to do what. Partnerships that are truly effective have a lot of added value to deliver, but an awful lot of organisations in the NHS and the rest of the public services in Wales spend a lot of time in partnership meetings and not necessarily delivering any change. You set out in one of the papers—and I cannot remember which one—a model of a successful partnership. It is roughly the same model as that we used when I was learning social work theory in the 1980s, so it is not rocket science, particularly on the issues of trust. Would you acknowledge as a confederation that we have huge problems with some of our partnerships in Wales, in that some are delivering well and some are not? Can you identify what you see as barriers to effective partnership working? I suppose that what I am looking for specifically is whether there are things that you, as a confederation, could suggest to the committee that we could recommend to the Government, such as steps for it to take to make it more likely that partnership working will be effective and not a fudge.

[50] **Mr Ponton:** On the right level of commissioning, the emphasis in the paper is on the fact that, for all commissioning, you cannot look at one level to undertake all commissioning, so that is what it meant by that. I am not saying that you cannot commission well, but you have to look at what you are commissioning and decide where that is best handled. That is the point.

9.30 a.m.

[51] Secondly, on partnerships, I spent some of my career in public health, in health promotion, and that sort of partnership involves not only health professionals but also the wider community, in facing up to health issues, and working together to resolve them. Research that I have done in that field shows that, across the world, because of human nature, partnerships are all very different and all have their own problems. Maybe the time has come for people who work in partnerships in health and social care to be judged on their contribution, and on what part their contribution plays to the overall outcome that is wanted.

[52] Public service is probably still plagued by empire and turf, whereas what we are looking for, particularly in clinical networks, are organisations and health professionals coming together for the better good of the patient and the community as a whole. People in those networks are quite rightly worried about their responsibilities, about how they will be held accountable, and what influence they have on how that network might be developed. So, clinical networks and partnerships go together. They have to work well as partnerships, and we have to take account of human nature. Often, in human nature, we must put aside the questions of, 'What is in it for me; what are the benefits to me and the contribution that I can give to people?'. Clinicians are very interested in their contribution to improving care and the quality of care, and, often, their worry with partnerships and clinical networks is that they will lose influence, become part of a bigger organisation and get lost in it. That should not be the case. That network and that partnership should be one of equals, with everyone making their contribution to the benefit of the patient.

[53] **Mr Davies:** To add to that, you asked whether there were any barriers, and I think that information is the key to this whole agenda. The development of a single electronic health record—which we hope will eventually lead to a single electronic health and social care record, with all the appropriate safeguards on information and access—will help to break down some of the boundaries that are there. Sharing information across boundaries will lead to a clearer patient pathway, which will, in turn, lead to a clearer organisational understanding of how these things should work. Therefore, underpinning all of this, the information agenda is vital.

[54] **Jonathan Morgan:** On the capacity of local health boards to commission cancer services, are there any particular challenges that LHBs face, and is there anything that they should be doing better? Secondly, what is the relationship between local health boards and the voluntary and charitable sector? We have heard a considerable amount of evidence to suggest that the local health boards do not see the voluntary and charitable sector as equal partners in the services that they deliver. Are you interested in, or concerned about, the relationship between the statutory and non-statutory sector?

[55] **Mr Ponton:** On the first part of the question, on what local health boards could be doing better, the huge issue underlying this and other areas of healthcare is commissioning. I believe that everyone among LHBs, NHS trusts, and the wider health world in Wales recognises that commissioning needs to be improved. However, one thing that we need to appreciate is that it is not just in Wales that commissioning needs to be improved; across the UK, there is now a much clearer view that commissioning is the key to making changes, improving the quality of care, and getting better value for money. That is not news. I was chief executive of a health authority 10 years ago, and my job was commissioning. It was

extraordinarily difficult then, and it is extraordinarily difficult now, because it is a complex business. However, that is not an excuse for not improving it and doing better with it. So, I am sure that you will know that, led by the Welsh Assembly Government, much work has been done on improving commissioning.

[56] The key factor with LHBs is that if commissioning is a complex business, you cannot have those skills everywhere, and that has always been the case. Also, for certain services, you need a critical mass to be able to have better relationships and to strike better deals with providers. So, it has been recognised that a lot of that will be better done at a regional level. In my opinion, that does not in any way undermine, and it should not in any way erode, the responsibility of local health boards in representing those in their local population who are in need.

[57] There is also a clear case in Wales for some specialist services to be commissioned at a national level. One problem is that, in cancer services, there is some confusion, and there has been from the start, about what would be best commissioned along other secondary care services as opposed to specialist services. I hope that the new commissioning framework, which will include a regional level of commissioning, will provide a much more effective way of brigading skills, will make the process much more effective and will clarify at what level commissioning should be undertaken. I should also mention—and Simon Dean has said this to you in the past—that we must not forget the importance of local cancer care in terms of palliative care, or the fundamental importance of the role of primary care. So, you have to think about what you want to provide, how you want to provide it and how you want to commission it. All these levels will be involved in the future.

[58] The voluntary sector issue is, again, a partnership issue. The voluntary sector works hard in difficult circumstances and it is always under pressure for resources. Local health boards have a wide range of partners and stakeholders to work with—using public money and their money—and they are under pressure. Building Strong Bridges, the strategy that was produced a few years ago, gave a direction and a protocol for joint working between health organisations and voluntary organisations, and set up a new infrastructure across Wales. I believe that there has been a big improvement in that regard. I have had experience in dealing with the voluntary sector in terms of palliative care; it is a very emotive service—people always want to do better for voluntary care and there will always be a need for more investment. It is one area where we have to ask, first of all, whether we are making good enough use of the voluntary sector. I am sure that we can always use the voluntary sector better, but it also about how that stacks up against all the other demands on public money. Relationships could be improved, and I think that the commissioning framework would be a good vehicle by which to question again whether we could be doing better in our partnership with the voluntary sector.

[59] **Jenny Randerson:** Modern cancer services require very specialist equipment and care in some cases, and where you need specialist care, you often need to reconfigure services. We have already had examples of local populations being very upset by the idea of the reconfiguration of services. Karen will put me right if I am wrong, but a case at the breast cancer clinic in Llandudno hospital comes to mind. You say various things on page 14 in your paper about the differences between patient and public involvement and the obligation on NHS organisations to involve and consult patients and the public. The recent consultations that have taken place on service reconfiguration have generally illustrated the fact that we do not have the issue of public consultation right. How, do you think, LHBs and trusts should be tackling the whole issue of the provision of more specialist services in terms of public liaison and ongoing public involvement, and not just involvement when there is a one-off issue for public involvement? It seems to me that we are getting a growing disparity between what the gut feeling of the public is in terms of local services, and what clinicians say has to be reorganised in order to provide the best standards of service. As politicians, we are torn both

ways here, are we not?

9.40 a.m.

[60] **Mr Ponton:** This is a hugely important issue, and we can all take these past 12 months as a sort of wake-up call on how we should be dealing with the public, and the fact that, if we really mean that we want citizen-based public services in Wales, that gives us a whole new responsibility in terms of how we engage. The problem is that we still seem to be making public engagement an event rather than a constant process—because of the need for speed in making a lot of these decisions, and then the need to get those right, as well as the huge amount of work that is needed to assess options, and often to explain the technicalities to the public. It may be that we have not explained the technicalities well enough, or that there is some emotive reason that makes it a difficult issue in the community, but we have to make this engagement a constant process, though there is a cost attached to that, namely time.

[61] I am sure that local health boards and trusts will not mind me saying that, although they have made big improvements, because the expectations of the public, their ownership of the national health service and the goldfish bowl effect in health have all changed things significantly, they must now consider a key part of their role as being in and among their community, constantly talking about health issues as they emerge. I also happen to believe that there are issues around governance, and the relationship of governance with the way in which local people can influence decision-making. It is not fair for politicians to think that this is simply a health organisation issue, or a public organisation issue—it is time for us all to stand up and say that the strategic issues, which provide immediate problems in relating to the public, have to be handled better. So, we are about to publish some work in the new year that will hopefully raise this issue, and I think that everybody involved in the consultation over the last year did their best in the circumstances in which we found ourselves, and I am certain now that the whole of the national health service will think much more carefully about how it relates, not only to the public and politicians, but to the press and media, in making this an ongoing story.

[62] Just to finish—and I am sorry if I am talking too much—the other side of this is that the public must take some responsibility here. We all have an obligation to accept that things must change—given the time spent on this issue, and the understanding of it, and considering that the relevant information is accessible, and that we have been constantly involved in the discussions around this. Those involved in changing the national health service and the services provided must ensure that the benefits and the issues are clear. Change is inevitable, and it is much better to shape it than just to wait for it to happen.

[63] **Jenny Randerson:** What role do you think that local health boards and trusts should have in order to ensure that the cancer networks, or the clinical networks, work better than they do at present? What could be done to improve matters?

[64] **Mr Ponton:** In the reading that I have done of late, one issue with the networks is still this problem of who they belong to, what they are there to do, how you share resources, and how you become more relaxed about authority and status—all those human-nature and organisational issues that have been, and will be, there forever. However, the issue that we in Wales have to address is that, if the idea of a clinical network is to create and manage a set of care plans that work better for patients and to make better use of our health professionals and our resources, there has to be acceptance in the modern NHS that that is a new way of managing things. People of my generation, for example, at all levels, have been brought up on managing organisations that have often been self-sufficient, and have been encouraged to be so in the past. Now, however, we are looking for a federation of organisations and health professionals that play their part and make their contributions. The Welsh Assembly Government issued a circular in 2005 underlining this point. The real determination now to

change, modernise and improve the commissioning process gives us a vehicle to say that we are going to underpin the role of clinical networks to make this more effective. It is clinical networks that can give advice on the national and regional levels on standards, service provision, change, training and learning and so on, and they have to be the right solution.

[65] **Dr Fowell:** I would like to comment on clinical networks as a clinician who works within one. There is general acceptance that networks are the way forward, but they are incredibly difficult to work in. When you bring five or six organisations together, you have commissioners who will agree that this is the way forward, and then they have to take that back and sell it to their own organisations, which becomes very difficult. Leaving one's hat at the door and sitting down to discuss matters in a sensible, non-parochial way is actually very difficult. Networks are evolving, but I do not think that we know what is the right way to deal with them yet, and we need to do a lot more work on that.

[66] **Mr Ponton:** Can I reply to that? If we were giving a PowerPoint presentation today on clinical networks and how they should work, everybody would say the same thing, namely how difficult partnerships are, because they are. I have found that, in managing change, there is always the issue of people asking, 'Why should I go along with this?'. Do you know what I mean? I have never worked in a clinical network, so it is very easy for me to say, 'This is the theory; it's great', but the point is that we know that there are clear benefits for everybody. One must ask whether people understand those benefits and how networks can develop, improve and enhance their professional or management practice or whatever. Do people understand that these things will make the management of pathways much clearer and better if responsibilities and purposes are much clearer? We probably need to reinforce the view that, regardless of what we want, the only way that we will provide modern and better services is by working closer together and trying to knock down those organisational boundaries. I am certain that one way to do that is to judge people much more on their contribution to the total outcome rather than having them manage their bit of what I am sure some people still consider to be their empire. They should be outward looking rather than inward looking. The pace of that can be forced by thinking about things such as targets, outcome-based measures and performance management. We can make things better, but it will not be immediate—I am absolutely sure of that.

[67] **Dr Fowell:** The big problem is that, as well as being judged on their targets, managers are judged on whether they come out financially level at the end of the year. If part of what you are asking a network to do is to make decisions about how its pot of money is divided up, its members are very reticent in giving up control of anything that has financial implications.

[68] **Mr Ponton:** I do not think that this is as much about giving up control as it is about being much clearer about what you have to give. In the NHS, for as long as any of us live, we will never escape the fact that there will never be enough money to do what everyone wants to do. We can always get better and more efficient, but, at the end of the day, there will always be something that we should be doing that we are not doing because we cannot afford it or because of different priorities. So, the psychology of this needs some work. That does not give us an excuse not to do it.

9.50 a.m.

[69] **Karen Sinclair:** How do you feel about the evaluation and commissioning of cancer drugs? It is a highly charged, emotional and emotive area. A huge amount of work is being done on cancer drugs, so it is an ever-changing scene. In recent years we have seen an increase in public awareness, which is not a bad thing. It is good that people are much more aware of what is available, because their feeling themselves to be equal partners in the discussion gives them a certain amount of equality and ownership of their care.

[70] However, occasionally we have seen it move on from that, when people take emotional direct action. That is grabbed by the media, and it can cause all sorts of distortions of the truth about drugs. Many women thought that Herceptin was going to be the miracle cure for every sort of breast cancer, and it is very difficult for a clinician to sit patients down and tell them that is not the case, because that is not what they want to hear. They want to hear that that drug will cure all cases. I would like to explore how you envisage handling this in the future, because the media interest is not going to go away; it will probably increase. How do you see this being handled for the benefit of patients on a pan-Wales level? I am not talking about financial implications. Often, we have found that clinicians have been left to deal with the ever-changing scene, so I would like some feedback on that.

[71] **Mr Ponton:** This is such a dilemma. The line for a considerable period of time—and it still is, really—has been that we must be conscious of local needs and services and the way in which care is provided. For as long as I can remember in this new management era, if you like, the NHS has faced dilemmas. There is always something new or something that would help a particular patient, and there is a discussion, which is partly about economics and partly about how to match up priorities. I am sure that all of us are very unhappy about what has been happening lately. Somehow, the system seems to be confused. There are arguments among health professionals and organisations such as the National Institute for Health and Clinical Excellence, and often, you and clinicians and others are stuck in the middle trying to make sense of this.

[72] I know that this discussion about cancer drugs will go beyond the UK. We have to look for a way to achieve more clarity with regard to how decisions are made. In particular, we need to take the pressure off local clinicians in some way. Again, there is a paradox: we know what we need to do, but, often, our taking one step will restrict the freedom of others. We have to come to terms with the fact that, if there are good reasons to use or not use a particular drug or treatment, we must make a firm decision about it, and that must be supported by everyone. At the moment, everyone's position, in one way or another, is being undermined. Whatever we do, we know that if it affects their families, people will want the best possible healthcare and treatment that they are told are available—we are all the same. The balance is getting that right when we can and also looking for the greater good. While the NHS is run with public moneys, as it is, which I personally think is quite right, we will never be absolved of these difficult decisions.

[73] **Jonathan Morgan:** To pick up the point raised by Karen on how we pay for new drugs and therapies, we were told by the Government that there was no new additional money to cover the cost of Herceptin and that the £5 million annual cost would have to come out of the uplift that you received and from efficiency savings. In your view, how sustainable is that as a general philosophy for the future, when we are likely to have more drugs and therapies coming on stream that could be more effective? As Karen points out, the public demand for that could be quite great. What process and relationship exists between you, as commissioners of services and as holders of the budget, and the Assembly Government, which will, at some point, be called upon to provide additional resources to cover those additional costs? How sustainable is that philosophy, which states, 'We are not going to give you any extra money; you have to find it within your general uplift and within efficiency savings'?

[74] You mentioned earlier the need to look at what is provided in the context of outcome-based measures—I think that that is the term that you used. In light of the fact that we are holding a review into cancer services, what analysis have you done of the outcomes that local health boards have achieved in commissioning services, and in the way that they commission them, with the money that they have to spend on commissioning those services? Obviously, what we do not have, and which would be quite useful, is some understanding of the impact—perhaps the benefit—of the way in which local health boards commission and pay

for adult cancer services.

[75] Finally, you obviously know that children's cancer services are commissioned by Health Commission Wales. I am trying to understand the rationale behind Health Commission Wales commissioning children's cancer services and local health boards commissioning adult cancer services; that becomes quite complex. Do you think that adult cancer services ought to be commissioned at a national level?

[76] **Mr Ponton:** In terms of these regular and forever problems of something coming on to the market, or a new treatment being discovered or brought in from other places as best practice, my message to health organisations in Wales is that they have an absolute duty to show that they are using the public money that they are given to its absolute advantage, with value for money. As we know, there is still some way to go in Wales to do that. There is a lot of improvement going on but a case in point recently about day surgery shows that there are things that we need to do.

[77] I think that the NHS in Wales is up for this challenge—it is unavoidable in any case—but we have to demonstrate that we are using public money to its best effect. Having said that, and being able to demonstrate that, it becomes a decision of priority; as an old friend of mine used to say, if the money is the money and you are using it as best as is possible, and then you have something that comes up for which there is no further resource, you either have to change things that you are doing to make space for it, or you cannot proceed. It is as simple as that. Therefore, there is always a case for public services to ask any government for more money, but there will never be enough money to do everything that we want to do. Unavoidably, if we have not already got there, we are soon going to get there, where some of these difficult and emotive decisions have to be made. That is not just for the health organisations; it is for the Welsh Assembly Government, the wider community of politicians, and the public. That is the problem right now. We know intuitively and for a fact that many of the things that we are doing are no longer fit for purpose or a priority, yet we have this real problem, because of public engagement, as discussed this morning, of achieving change. We have to find a way of sensibly achieving change, because you cannot become efficient, efficient, efficient every year to release enough money to provide new treatments. It is just not feasible.

10.00 a.m.

[78] You ask about the analysis that the confederation has done of these things; we are not set up to do that. The sort of work that we do, as you have seen, is that we look at policy and interpret and analyse it, and we also look carefully at what other people are doing. So, for example, LHBs will be working with the National Public Health Service and other institutions, such as the Wales Centre for Health, to look for trends of improvement. We are using the information that we have now to make assessments of where we are going. I was told recently that the information base for cancer services is drastically improving and is now demonstrating a lot of what we want to look for, such as whether our investment is achieving what we want. My role is to snap at ankles to ensure that these systems are in place. I am not geared to do the sort of analysis that shows too much scientific information about where they are leading.

[79] The last question was about where commissioning should take place for adult cancer services—

[80] **Jonathan Morgan:** I know that you touched on that, but it is regarding the difference between that and what Health Commission Wales does for children's cancer services. People often do not understand why there is a different system for one compared with the other.

[81] **Mr Ponton:** Quite rightly. When Health Commission Wales was set up, it inherited the situation from the Specialised Health Service Commission for Wales, as you know, which was set up by health authorities to help them to differentiate between the way that things were commissioned. In some ways, because of the timescales and the need for major change, it had to be a little bit of a sledgehammer to crack a nut. Over time, we are increasingly finding the things that do not fit well. My position, and I am sure that people agree with me, is that, now that we are going to change the way that we commission services, it is the time to say what is best done where. You have seen the report; there are various criteria that you can use to judge that. It is clear to me that some things must continue to be done nationally, in the Welsh context, because of expertise and the way that you deal with providers, but one would also expect as much as possible to be done at a regional level, and sensitively, in terms of local needs and the relationship that those services have with primary care and the voluntary sector. So, I cannot give you an answer. What I can say is that there is a problem, it is recognised and we will be advocating that a change in the commissioning framework should also now question what Health Commission Wales does, what the regional structure can do and how they relate to each other—they must be closely related and based on need, and go back to the sovereignty of the health boards.

[82] **Helen Mary Jones:** I am a bit concerned that you do not have a definite answer to recommend, because, since you represent the main commissioning bodies and some of the significant providers, it would be helpful for us if you had a clearer view. However, if you have not, you have not.

[83] In your last answer, you referred to this idea of the local health boards as being sovereign and talked about their pooling sovereignty through regional networks, which I can understand. On page 14 of your second paper, you talk about local health boards, and say, with regard to commissioning,

‘Getting it right is everyone’s business, not just the LHBs’. LHBs have a particularly important role, however’.

[84] That is clear. You then say,

‘and we must support them in developing commissioning capacity’.

[85] In that context, who is that ‘we’? How might that support in developing commissioning capacity be provided? Even if we go down the road of pooling capacity, it still has to be there, even if, for some local health boards, it is the capacity to let go and let the networks make a decision. So, to summarise the question, who is the ‘we’ who need to be supporting the local health boards in developing their capacity and what specifically should we be recommending to the Government as needing to be done by that ‘we’, whoever they are?

[86] **Rhodri Glyn Thomas:** Before you answer, Mike, I will bring Jenny in.

[87] **Jenny Randerson:** I wanted to raise a slightly different aspect to this. In your paper, you refer to partnerships between LHBs, and about their working more closely together and so on. Do you think that public service boards, which will force the partnership to be at a tightly restricted geographic level in each locality, will distract LHBs from working together on a wider geographical spread? You will have partnership at that level between the same sorts of organisations contrasting with partnership between different organisations in one locality.

[88] **Mr Ponton:** Before I answer those questions, I want to say that I think that it is unrealistic of you to expect me to come here with answers to how one can perfectly put a

framework in line for commissioning. We are definite about the fact that there is an absolute need for regional commissioning and for some national commissioning and we must not forget how all of that relates to what is done at grass-roots level in primary care and voluntary care. I am sure that you have seen the list of the types of services, treatments and care that are involved, and you do not have enough time for me to go through that and to explain it to you. What is important now is to get the framework right and then you need expert discussion about what should be done where. So, I do not think that I have come here inadequately representing the view of the NHS, because I think that the framework is the starting point. I am happy to talk to you about that in more detail outside the meeting.

[89] The 'we' meant all of us in the NHS. You will be aware that the confederation represents trusts and LHBs and that is sometimes a sensitive area of representation. However, the message from us is that we are all in this business together and we all have responsibilities for making commissioning work. We do not want what we are seeing in England, where measures such as payments by results are introducing gaming and playing for advantage in using tariffs and so on. We do not want that in Wales. Commissioning can become a powerful vehicle for change and improvement, and if we all want it to work, we can make it work. It goes back to the partnership issue, does it not?

[90] On partnerships and partnership boards, I think that we are talking about different strata. Partnership boards will be helpful in reinforcing the local strategies for health, social care and wellbeing. They will look at local things. However, what we are talking about with commissioning is making sure that where critical mass is important, and where you might say a more expert approach to commissioning comes in, then they both link together, that they are not competitive and they will not collide, but will complement each other.

[91] **Rhodri Glyn Thomas:** Diolch yn fawr iawn i Mike Ponton a Jonathan Davies am eu cyfraniad. Mae hwn wedi bod yn sesiwn werthfawr. Mae'n cloi ein sesiynau ar y gwasanaethau canser. Wedi'r toriad, bydd sesiwn gaeedig. Nid wyf o blaid sesiynau caeedig ac yr wyf yn ceisio eu hosgoi yn y pwyllgor hwn, ond mae hi'n angenrheidiol o ran dwyn ein casgliadau a'n hargymhellion at ei gilydd ar gyfer yr adroddiad. Yr wyf yn ymwybodol na fydd y Weinidog na'r Dirprwy Weinidog yn ymuno â ni ar gyfer y sesiwn hynny, fel sy'n briodol. Fodd bynnag, gan mai dyma ddiwedd y sesiwn hon, nodaf ein gwerthfawrogiad i'r Gweinidog a'i ddirprwy am eu parodrwydd i gynnal deialog gyda'r pwyllgor hwn. Mae hynny wedi bod yn werthfawr iawn a gwerthfawrogaf y ffaith fod y Gweinidog a'i swyddogion wedi bod yn hyblyg ar nifer o faterion digon dadleuol yr ydym wedi eu trafod yn y pwyllgor hwn. Yr ydym yn gwerthfawrogi'r deialog hynny yn fawr a chredaf ei bod yn fodd i ni sicrhau bod trafodaethau'r pwyllgor hwn yn gyfredol ac o ddiddordeb i'r cyhoedd. Dymunaf Nadolig llawen iawn i'r Gweinidog, y Dirprwy Weinidog a'r swyddogion. Dymunaf hynny i weddill y pwyllgor yn ddiweddarach.

Rhodri Glyn Thomas: Thank you very much to Mike Ponton and Jonathan Davies for their contribution. This has been a valuable session. It brings our sessions on cancer services to a close. Following the break, there will be a closed session. I am not in favour of closed sessions and I try to avoid them in this committee, but it is essential in order to bring together our conclusions and recommendations for the report. I understand that neither the Minister nor the Deputy Minister will join us for that session, as is appropriate. However, as this is the end of this session, I note our thanks to the Minister and his deputy for their readiness to enter into a dialogue with this committee. That has been very valuable and I appreciate the fact that the Minister and his officials have been flexible on a number of quite contentious issues that we have discussed in this committee. We value that dialogue greatly and I believe that it is a way for us to ensure that this committee's discussions are up to date and are of interest to the public. I wish the Minister, the Deputy Minister and his officials a very merry Christmas. I will convey those sentiments to the rest of the committee later on.

[92] I noted our appreciation of the work carried out by the expert reference group earlier. Some of you might have been outside when I did that. We are very grateful to you and we will be grateful for your contributions in the closed session when we bring together recommendations for the report.

[93] Torrwn yn awr am chwarter awr ac We will now break for a quarter of an hour
ailymgynnull am 10.25 a.m.. and will reconvene at 10.25 a.m..

Daeth rhan gyhoeddus y cyfarfod i ben am 10.10 p.m.
The public part of the meeting ended at 10.10 p.m.