Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

07/06/2017

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Others in attendance

Grant Duncan	Dirprwy Gyfarwyddwr, Gofal Sylfaenol, Llywodraeth Cymru Deputy Director, Primary Care, Welsh Government
Vaughan Gething	Aelod Cynulliad, Llafur, Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon Assembly Member, Labour, Cabinet Secretary for Health, Well-being and Sport

Dr Richard Lewis	Arweinydd Clinigol Cenedlaethol ar gyfer Gofal Sylfaenol, Llywodraeth Cymru National Clinical Lead for Primary Care, Welsh Government

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Sarah Sargent	Dirprwy Glerc Deputy Clerk
Sian Thomas	Clerc Clerk
Dr Paul Worthington	Ymchwilydd Researcher

Dechreuodd y cyfarfod am 09:15.
The meeting began at 09:15.

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

[1] **Dai Lloyd**: Croeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1, a allaf i estyn croeso i fy nghyd-Aelodau? Rydym ni wedi derbyn, yn naturiol, ymddiheuriadau oddi wrth Julie Morgan, ac mae Huw Irranca-Davies yma fel dirprwy. Croeso, Huw. Hefyd, rydym ni wedi derbyn ymddiheuriadau oddi wrth Angela Burns, ac mae'n hyfryd i weld yma hefyd Suzy Davies fel dirprwy. Croeso hefyd i Suzy.

Dai Lloyd: Welcome to the latest meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. Under item 1, may I welcome my fellow Members? We have received, naturally, apologies from Julie Morgan, and Huw Irranca-Davies is here as a substitute. Welcome, Huw. Also, we've received apologies from Angela Burns, and it's great to see here as well Suzy Davies as a substitute. Thank you and welcome to Suzy.

[2] A allaf ymhellach egluro, yn naturiol, fod y cyfarfod yma'n ddwyieithog? Gellir defnyddio

Can I further explain, naturally, that this meeting is bilingual? Headphones can be used for

clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1 neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i atgoffa pobl, ac yn benodol, felly, yn yr ystafell newydd yma, i ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall yn gyfan gwbl, neu fe fyddan nhw'n amharu ar y system sain? Ac a allaf hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu?

simultaneous translation from Welsh to English on channel 1 or for amplification on channel 2. May I remind people, specifically in this new committee room, to turn off their mobile phones and any other electronic equipment completely, or they will have an effect on the sound system? And may I inform people that we should follow directions from the ushers should there be a fire alarm?

09:16

Ymchwiliad i Ofal Sylfaenol: Sesiwn Dystiolaeth 10—Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Inquiry into Primary Care: Evidence Session 10—Cabinet Secretary for Health, Well-being and Sport

[3] **Dai Lloyd**: Gyda chymaint o hynny o ragymadrodd, fe wnawn ni symud ymlaen i eitem 2 a pharhad i'n hymchwiliad i ofal sylfaenol a'r clystyrau. Sesiwn dystiolaeth rhif 10 ydy hon y bore yma, ac rydw i'n falch iawn o groesawu Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon, Vaughan Gething, yma i'r cyfarfod—bore da a chroeso—ynghyd â Grant Duncan, dirprwy gyfarwyddwr gofal sylfaenol, Llywodraeth Cymru—bore da ichi a chroeso—a hefyd hen ffrind, Dr Richard Lewis, arweinydd clinigol cenedlaethol gofal sylfaenol yng Nghymru, nawr, yn Llywodraeth Cymru. Bore da, Richard.

Dai Lloyd: With those few words of introduction, we move on to item 2 and continue with our inquiry into primary care and the clusters. This is evidence session No. 10 this morning, and I'm very pleased to welcome the Cabinet Secretary for Health, Well-being and Sport, Vaughan Gething, here to the meeting—good morning and welcome—as well as Grant Duncan, deputy director of primary care, Welsh Government—good morning and welcome—and also an old colleague, Dr Richard Lewis, national clinical lead for primary care, now, in Welsh Government. Good morning, Richard.

[4] Rydym ni wedi derbyn eich

We have received your written paper.

papur ysgrifenedig. Mae hwnnw gerbron ac yn naturiol mae Aelodau wedi ei ddarllen gyda manylder, fel y buaswn i'n ei ddisgwyl, ac yn seiliedig ar hynny mae gyda ni gyfres o gwestiynau. Felly, yn ôl ein harfer, awn yn syth i mewn i'r cwestiynau hynny, gyda chaniatâd, ac mae'r cwestiynau cyntaf o dan law Caroline Jones.

We have that before us and naturally Members have read that paper in detail, as I would expect, and based on that we have a series of questions. So, as usual, we'll go straight into those questions, with your permission, and the first questions are from Caroline Jones.

[5] **Caroline Jones**: Good morning, everyone. I'd like to ask questions, please, on reducing the demand on general practitioners and secondary care—the impact that clusters have. The hard evidence is that the impact of clusters seems limited and small in scale, so could you tell me what quantifiable data there are about clusters reducing demand for GP services on a significant scale?

[6] **The Cabinet Secretary for Health, Well-being and Sport (Vaughan Gething)**: The evidence about reducing demand is how demand is changing because, actually, if we successfully change the demand that comes through the door for a GP to see, that's because another health professional's seeing that person. I'm not going to try and suggest that primary care clusters—and it is a primary care cluster; it's that wider team working together—is going to mean that GPs are suddenly going to be able to put their feet up. But we've got a number of examples in different clusters of how different professionals are able to save time for GPs, whether it's physiotherapists seeing people who would otherwise see a GP, or that it's pharmacists, and a range of health boards, I know, are provided with evidence about the number of hours of time that they've saved. So, it is about saying there is less work for GPs to do. It's changing the nature of the work so it's more appropriate for GPs but also more appropriate for those healthcare professionals. And we still have a job of work that isn't just about primary care clusters on shifting work away from secondary care into primary care. Of course, we'll be shifting more work into primary care to deal with, and, again, that means we need to change the way the work is currently done in primary care as well.

[7] In terms of reducing the demand, I think that's probably the wrong way to look at it, if we're just being perfectly honest, because there will always a demand for how people are dealt with, whether it's about making sure they go to a pharmacist instead of coming into a GP surgery for an

appointment. It's about how we deal with that demand across our whole system and deal with it more appropriately, which is what our clusters are there to do, rather than trying to turn the tap off in terms of demand. That, really, is a bigger public health question, to actually interrupt demand, and I don't think the inquiry's really asking us about those public health challenges that we regularly discuss on smoking, diet, exercise and alcohol intake. But this is about how we change demand and make it more appropriate.

[8] **Caroline Jones:** But the evidence seems patchy and limited, so can you elaborate on that? Do you think it's too early to say, or do you think we'll get more evidence as time goes on—you know, better evidence or more quantifiable evidence?

[9] **Vaughan Gething:** Well, the evidence base is developing—that's being perfectly honest—because we're relatively early in the journey on primary care clusters, and that does mean that you won't have, and I won't have, all the evidence we might want to see now about the way in which demand is being managed differently, and, hopefully, more successfully. And when we do get that evidence in greater number, and greater measure, we'll also learn things that haven't worked as well as we might have wanted them to. And some of the stuff we've already done—. There are different tracks for this to happen, of course, but each health board should look at, and evaluate with their clusters, how successful the work has been together. But also, we've got work programmes, for example, going through this year, and they're going to start to report in spring next year to look at the work that's already been done with clusters. We've got evaluation that Public Health Wales are leading.

[10] So, there are different streams of work that will look at what we do, and I've drawn together another national primary care event for October. And part of what I want us to be able to do is to understand what our developing evidence base is, because as well as waiting for a formal evaluation, we should have intelligence going through our system as we carry on that tells us, 'Well, do we think this different way of working is really delivering? Is primary care audiology really delivering the gains we want it to? Is it still the right use of money?' Whereas, actually, if we think there's a real strong evidence base that's been developed around the use of physiotherapy and the use of pharmacy, then how do we do more of that and think about what's going to be successful in delivering that.

[11] So, I wouldn't try and pretend to you, or anyone else, either in this room or in a private conversation, that we have an evidence base in the here and now that can tell us everything that we want to do, and how we'll do it, and what that will mean, because, as I say, it is a developing piece of work. But the point about starting off on this journey, and starting to go down the route on this journey, is that we recognise that doing nothing is not an option. We recognise from the evidence that drew us into having clusters, the evidence base about planning healthcare together in a primary care setting, in roughly this sort of size—and it is about having a properly sustainable form of primary care as well, which has to be a way of changing the way we deliver primary care—we will only get that if we get healthcare teams to work with each other in different professional groups.

[12] So, I think that we'll have more evidence with each successive quarter that we can come back with, and I appreciate that there will be a report and a debate, but, equally, I'll expect that the committee will want to come back to this at some point in the future as well, and I'd be more than happy to come back again. As I say, we expect to have an evaluation ready in the spring, and, obviously, we'll make that available, when we've got it and considered it. And if the committee want to follow-up on that then, I'm more than happy, because this has to form the decisions that we make with healthcare professionals and the public, and to inform what we're doing, both on what has worked and what hasn't, and I expect the evaluation to tell us both of those parts.

[13] **Caroline Jones**: Okay, thank you. Does anyone else want to say anything on that question?

[14] **Dr Lewis**: I would say that there's early feedback from primary care clusters and practices that the range of initiatives that they're taking forward is having an impact, whether it's through primary care clinical pharmacists working in primary care, or attached social workers in some clusters. We have some clinical outreach teams that are supporting GPs, in terms of visiting care homes and mitigating some of the demand and the pressure on a practice, and where that's working well, there is anecdotal—. As the Minister's already said, we will be looking to evaluate more thoroughly the sorts of initiatives that are having the greatest impact, so that we can pursue those more aggressively. But, certainly, there is a range of initiatives that are funded through the cluster programme, and elsewhere, that are having early signs of showing that we are supporting GPs in responding to the demand that they have been experiencing.

[15] **Caroline Jones:** Okay, thank you. My next question: the Welsh Government's primary care development plan said that clusters would play a significant role in moving services out of hospital into the community, but there seems to be little to show, again, that this is happening. So, are you confident that we'll see real evidence of impact on secondary care, and can you say when you think this would be likely?

[16] **Vaughan Gething:** We are seeing some of that movement, but part of the challenge is that clusters have to be there to be able to make sure that primary community care can deal with the shift in the work that is taking place. And, again, so much of this is actually about how we make really quite significant system reform, while the services are still provided, and we shouldn't pretend this is easy, or that there is a simple and easy answer, because there isn't. We'll find experience that will differ in different parts of the country, either because of the nature of the population, or actually about the way in which those healthcare professionals are able to work together. So, I expect to see a differing pace in movement, and in different services. But an example we've given in the past—primary care cardiology. Well, that has moved a significant chunk of the service out of secondary care into primary care, and it's been dealt with successfully, but that requires a team of professionals working in a different way in primary care, as well as secondary care professionals working in a different way. That, then, is a better experience for the individual citizen. It's part of our move to having care closer to home. If we said that we weren't going to do anything to the model of primary care—think about the way it was five years ago, but once they've shifted services around—I don't think we'd be able to do that, and I think we'd be loading more pressure onto those professionals in a way of working that we recognise wasn't going to meet the demands of 10 years hence, let alone 20 or more as well. So, this is quite difficult, but big system reform change that's happening, and, as I say, it's working because we've committed to doing something with money that's come with it, so there's freedom to make choices. And equally, the professional groups themselves have brought into it in a way—. To be perfectly honest, Chair, at the start of this programme there was a fair amount of scepticism amongst the workforce that this would work, and whether it would be just another way of using up healthcare professionals' valuable time in meetings to fulfil an agenda and fill forms out for the Government. Broadly, I understand that that cynicism would have been there, but broadly, we've seen a significant shift in opinion from not just the GP workforce, but the wider primary care workforce. It's more about how we make it work rather than, 'Is this the right

thing at all to do?' That in itself is quite a significant shift, and it still is for me about how we make this work and get the best from it, because otherwise we won't see the shift in services and we won't see the shift in the ability to deal with demand that we all recognise is coming.

[17] **Caroline Jones:** So, you think that in the medium and long term we'll see the benefits more so than now, and forward planning will be fruitful—

[18] **Vaughan Gething:** We can see some individual examples, but for the wider system shift, actually, that's part of the point about the evaluation of the service—what we think will work and why, and to give us a more rounded view on the shift that is already taking place. But if we can't not just plan how we want to deliver the service, and this is blocks of planning—. And if I may say, Chair, there is a bit of a tension between saying to groups of healthcare professionals, 'Here's some money, get on and plan and run and deliver the service yourselves', and so letting people get on and innovate, which lots of people say they want, and at the same time the demand for, 'Well, where's the evidence on what's working and how do we do more of that?' And it's about how we bring different groups of people together with demand that should exist within each of those clusters, actually, from professional to professional about what they think is really working, what the evidence is, what's a good use of money, a better experience for them as staff, but also a better quality of healthcare to be delivered with and for the citizen as well. So, I think we'll see more of this as we can go into the medium and longer term as well. But I think there's an encouraging set of statistics and evidence on a range of different fronts already that gives us some confidence about moving forward as well.

[19] **Caroline Jones:** Okay, thank you. And finally, the Cabinet Secretary's submission states that 2017-18 will be the year where health boards will begin mainstreaming successful schemes or, indeed, stop the schemes that haven't been delivering. Is this going to happen, and what's going to be the criteria for identifying success and identifying the failure of some schemes?

[20] **Vaughan Gething:** Part of what I said earlier is that part of what I'm trying to inject into our system is a sense of urgency and pace, which I've said before in this forum and others. And that's why I'm looking to have a primary care event in October to make sure that people understand that there's a continuing ministerial priority for primary care to be a focus, for clusters to be a way of working to deliver that shift in primary care and, again, to understand whether there are early lessons that we can take

forward about what we need to do, and what we need to try and shift towards as well. The evaluation that I mentioned earlier that will come out in spring next year will then tell us something about where we think organisations need to be, both health boards, what Public Health Wales would have to do in terms of evaluating presenting evidence as well, but also the job of work of persuading professionals and the local populations they live with and serve that there is a significant change to be made, whether that's in access or whether it's in the mix of healthcare professionals that they need. We'll have different lessons to learn, but in answer to your simple question, 'Will this happen in 2017-18?', I would say 'yes'. That's our very clear expectation, and there's a need that isn't just driven by politicians; there's a need that is driven by demand in the system that is recognised by healthcare professionals themselves of the need to continue to do things differently. Otherwise, standing still will see us getting knocked over.

[21] **Caroline Jones**: Okay, thank you.

[22] **Dai Lloyd**: Suzy, roedd gen ti gwestiwn atodol yn y fan hyn.

Dai Lloyd: Suzy, you had a supplementary question here.

[23] **Suzy Davies**: Yes, just on this point, I take what you say about evidence-gathering at the moment, and that it will be done formally at some point in the very near future, but you mentioned, I think, Dr Lewis, some anecdotal evidence of success. The committee's had some anecdotal evidence where there isn't success as well. We've got Dr Ian Harris saying that often—where he gets 'often' from, I don't know—they don't reduce GP workload.

09:30

[24] Have you been able, at this very early stage, to accommodate that evidence and say, 'Okay, well it's not working with you at the moment. How about trying this instead?', or is that a level at which you don't engage, and you have to let, say, the health board say, 'Try something else instead'?

[25] **Vaughan Gething**: Richard might want to carry on, and Grant might want to say something about workloads as well, because we've both met with GP leaders who are leading clusters as well, and the nature of that conversation has changed. There's been recognition there. But you won't see an even level of recognition and acceptance. People move at different paces. That's part of it.

[26] **Suzy Davies**: I accept that, but you've been able to—

[27] **Vaughan Gething**: But I do think, in terms of the conversations Richard's had with local medical committees locally about the way in which they see the workload changing, as opposed to—. As I said earlier, GPs aren't going to be less busy any time soon, but it is about making sure they're dealing more appropriately with their time, and what only they can do, and should do.

[28] **Suzy Davies**: All I want is reassurance that you have been able to take some early reform action.

[29] **Dr Lewis**: And there are examples. Three I would point to would be the Neath collaborative, where practices are working together, using clinical nurse triage, using a range of multidisciplinary staff, advanced nurse practitioners, physios and counselling services in a hub that people are referring to. So, the practice is using those services in a collaborative way, which is enabling them to get patients seen quicker and also is relieving the workload. So, feedback from them, and also their own evidence, suggests that they are able to provide better and earlier appointments, and better access for patients. I think, in Powys, we have a community social enterprise sort of arrangement, and early reports from them are that, because they have the opportunity through cluster working to work collaboratively, to explore new roles in a primary care setting, they are also having some impact. It's early days in terms of this, but there is early feedback from practices. Where it's working well, in all the health boards, and within health boards, clusters are at different stages of maturity, and therefore developing their initiatives in different ways, really. But where people have been ahead of the game because of past experience, they are making more progress and there is early optimistic feedback that what we're driving forward is having an impact. But that's not room for complacency. It gives some degree of assurance that the programme's moving in the right direction.

[30] **Vaughan Gething**: I've met doctors in south Powys and I've met doctors in Neath in the Pacesetter there, but also in Prestatyn as well, and they've all said they wouldn't go back, and I think that's really instructive. They acknowledge that they weren't all completely sold initially on the idea. They moved with some reluctance, but whether it's about not going back to the system of previous triage, whether it's nurse-led triage in Brecon or GP-led triage in Neath, or if it's about having a clinical pharmacist come in, what

was interesting as well was that the GPs in Brecon said that they didn't realise how much work had been taken away from them until that person went on leave and they had to go back to doing what they were used to doing. They are saying, 'This is getting in the way of doing all the things that I think are much more important,' and 'How did I cope before?' So, there is some reflection and recognition.

[31] But, in moving forward and in change, often once you've made a change, people are then quickly saying, 'This is now normal', and forget about the progress that has been made. Partly, the evaluation should help us to remind ourselves about what progress has been made and again the point about the pace and the urgency of it. But I hope that does give some real assurance that there is a real expectation from Government, but also within the service we will take that step back to look properly at the progress we've made, how far it has gone, and what more we still need to do. And of course it will, as I said earlier, tell us those things that I don't think have worked as well as we want them to—the things that we'll need to stop doing.

[32] **Suzy Davies:** That's okay. Thank you, Chair.

[33] **Dai Lloyd:** Mae'r adran nesaf o dan law Rhun, ac rydw i'n credu bod rhai o'r materion hyn wedi cael eu hateb eisoes, ond mae'r llawr i ti.

Dai Lloyd: The next section is with Rhun, and I think some of these issues have been answered already, but the floor is yours.

[34] **Rhun ap Iorwerth:** Yes, I'd like to press a little bit further on the evaluation theme, if I could. I appreciate that you're pledging an evaluation in the spring of next year. Of course, that's almost a year away, and, in order for us to be able to have a worthwhile evaluation published then, there needs to be ongoing evaluation. It has become clear to us, I think, as a committee, that there are real concerns about the level and the mechanisms that are in place for that ongoing evaluation. For example, Cwm Taf university health board say that evaluation work ongoing now isn't focusing specifically on the delivery of outcomes. Well, surely that's what we need to be measuring. Whatever you're looking at next year, what is being done now? What are the mechanisms in place?

[35] **Vaughan Gething:** On a range of those areas, like I said, there's a recognition that, in the here and now, we couldn't give, ourselves or individually, all of the assurance we might want to have in the here and now, but we have thought and designed in a point in time in the programme of

clusters that is coming up now, starting in the autumn term, and having an evaluation report in the spring next year that will tell us—

[36] **Rhun ap Iorwerth:** So, nothing is being measured now.

[37] **Vaughan Gething:** No, that isn't what I'm saying. I'm saying we're having the evaluation done then to give us that formal stand-back and look at how far and how much progress we've made. We've got a whole range of process measures in place as well. And, there's a broader challenge for our whole system about measuring outcomes and what those outcomes are. So, lots of measures that we use, for example, are about whether people have been referred to a physio appropriately, or whether they're taking up mental health counselling and support. They're often process measures and what is then the outcome of that treatment.

[38] It's partly because—and you'll know this—it's much easier to measure process in terms of time and volume. We do lots of that. Some of that is helpful to a point and some of it isn't. What I don't want to do is try and commit to a series of measurements that will measure processes in a way that is unhelpful, but to have the evaluation in terms of looking at, 'Well, what do we think we've achieved, and how, when and why?', and that'll be objectively done as well. It's more than about our continuing work on trying to develop outcome measures for primary care as well. That actually sits outside cluster work; it isn't just about the work of clusters, but it is about what outcomes we are delivering and are they the right sort of outcomes too,

[39] **Rhun ap Iorwerth:** You've started to answer the question, which is: what, actually, is being measured now? You mentioned those processes and mechanisms that are in place. Expand on that, if you could, so that we know what is being measured now that will help you when you bring together that evaluation, to see if things are working, and if we're getting specifically the outcomes for patients that we desire.

[40] **Vaughan Gething:** Well, that comes back to the challenge that I just said about measuring process. Some of those process measures can be really useful. For example, the time that GPs no longer have to undertake dealing with certain activities, because there is then more time for them to see complex patients. But that doesn't then tell you about whether there's an improvement in outcomes for those people. It'll tell you lots of things about the experience, both for the staff and for the patient, but it can't tell you something always about outcomes. I'll ask Grant to come in, because there is

work ongoing broadly on outcomes, but also on the measurements that we currently have already. It might be helpful if you said a bit more about the design of the evaluation that's already gone and also that we're undertaking from autumn onwards, but also about the Public Health Wales work, as well.

[41] **Mr Duncan:** Several things. One is that there is an existing set of measures that health boards look at, but they are generally process activity-based measures. In recognising that, there's another set that's been introduced over the course of this year. Some will be ready to go quite quickly, others will take more time to get the actual data underneath it. They're tending to be more outcome focused, either based upon patients' experience or different activity levels, like how well we're doing different things like diabetes or things like choice of care. So, we expect those to become more widely used over the course of this year, and that work is being driven and worked through by the directors of primary care.

[42] The work of Public Health Wales, they are letting a contract, which goes out this month and will report next February, which will be looking at the Pathfinder/Pacesetter work. But, I think, importantly, it doesn't start from a zero base; the actual work itself has been peer reviewed as people go along, and there's an emergence model that comes from that. So, some of the methodologies and the research looked at has been to say, 'Well, in the primary care plan, there are a number of outcomes mentioned. How are they being achieved?' It also says, 'In terms of the actual emerging model, what has been successful and are there any more clues as to how best practice can actually be picked up and spread?' I think, the way that the research goes, I don't think we'll be waiting until the end report comes up in February; discussions come on and you pick up things as you actually go along. So, that should be informative.

[43] The other evaluation is actually through different—. Not only are there national events, but each individual health board tends to have their own events where people get together to actually see how they're doing. I agree that some of that is more qualitative, but, at this point in time, that's also very important.

[44] **Rhun ap Iorwerth:** I can see and I appreciate that you're confident that what you think you need to measure is being measured, and we'll see what happens in the evaluation. Is it a concern to you that those involved in cluster work, be it Community Pharmacy Wales calling for national metrics for clusters, or Cwm Taf, as I said, wanting more focus on delivery of outcomes,

or others saying that there's very little evidence of clear mechanism of evaluating the progress of individual clusters—? Is it of concern to you that those out there delivering for you don't know what's being measured and if their progress is being assessed as well as it should?

[45] **Vaughan Gething:** Well, I talk regularly to all of those stakeholders about where we are on a range of different things. They understand the programme that's being taken forward, they understand the importance attached to it, they understand a different way of working. I think it's quite understandable that they will raise questions about how this is going to be measured and how we will see how not just our interest, but the broader public interest is taking account of that. But, I think, when you do see the evaluation reports coming forward, they will answer a lot of those questions. But, in any of this, as you'll know, Rhun, there'll always be more questions to ask, because we make choices about how much time and effort we spend on evaluation and how much time and effort we spend on actually delivering the service. So, I'm comfortable about the level of evaluation that we have coming up, about the report that we'll get formally in the spring, but, actually, about our ability to understand more about what is working and what isn't working as that evidence base continues to develop across the country. And it will continue to develop, as I say, at a different pace, because there is a different level of maturity within each of those clusters.

[46] **Rhun ap Iorwerth:** And one last question. I'll put to you a quote from one of our witnesses, who saw the importance of measuring and making sure that the right investment goes into measuring the success of clusters. Dr Jane Fenton-May from the Royal College of GPs said,

[47] 'I don't think anybody has put any money into actually producing evidence about care for the patient and whether that is improving or not improving',

[48] as a result of clusters. That's pretty key when you're looking at how we're measuring and if we're leading to better outcomes.

[49] **Vaughan Gething:** I think we'll be able to, from the formal evaluation we we're having done, draw out what a patient experience looks like, and we'll be able to draw out more on that evaluation about what that means in terms of outcomes. Because, for lots of people, the complaints that we get as politicians, whether it's me as a Minister, or people in this room, are often about people's experience of care. You do occasionally get people saying, 'I

think the wrong decision was made', but most often it's about how people are cared for and their experience of that care that drives how people feel about the quality of the service. So, I expect that we will have more of that as we come through. And there's something here about understanding how healthcare professionals who work in communities and often live in them as well, understand the experience for the patient as well, as well as their own staff. So, some of this is about how we gather that in a way that is intelligent and feeds into both the formal evaluation but also, as I've said several times before, developing the evidence base on the real impact of cluster work, and whether it's making the sort of difference that we all expect it to and we recognise that we need it to for the future of primary care.

[50] **Dai Lloyd:** Reit, mae'r cwestiynau nesaf ar y tîm amlddisgyblaeth, ac mae Suzy'n mynd i adrodd y rheini.

Dai Lloyd: The next questions are on the multidisciplinary team, and these questions are from Suzy.

[51] **Suzy Davies:** Yes, just a few questions about the operational practicalities of multidisciplinary team working, because, obviously, it looks very different in different parts of Wales. One of the issues that arose was that of employment and who's responsible for employing various personnel within the clusters. We have some witnesses who objected in principle to clusters employing their own staff on the grounds that those individuals weren't able to manage training and clinical supervision, if you like. Is that feedback that you've had as well in the early stages of evaluation?

[52] **Vaughan Gething:** Yes, there's an active conversation about the employment of different staff. What we've been able to successfully do is get more hands into primary care where the moneys have been spent. It's no surprise that the great majority of the moneys are being used on new staff to shift the way in which the service works, but there is a conversation about who should be the employer. For example, you've got a federation in Bridgend that will now have a legal personality, we've got a community interest company in southern Powys, and there is an active conversation on whether they should be the employer or whether health boards should be host employers.

09:45

[53] Most of the time, health boards end up being the host employer, but then that person is practically managed and works within the service, and it's

part of our conversation to have about do we think that we should mandate and say, 'This is how we want it to work' or not. And, again, that's part of the tension of saying to people, 'Here's money. Here's the latitude to get on and do something and innovate', and then saying, 'Actually, looking at it from a more national level and taking a step back, do we actually think the right thing to do is to make sure that all the staff end up being employed in a different way?' But, you know, this is part of the challenge we have already in the way that, in individual practices, staff are employed: is a practice nurse an employee of the health board or an employee of the practice? So, these are challenges that we already have, and let's not pretend this is a new thing. What highlights it is the fact there's new money available for clusters to have to work together to spend that money. So, it's about different groups of general practice and other professionals being able to say, 'Here's a priority. Here's what we want to deliver that', and, if it is about more staff, then that challenge arises, and because you've got groups of people looking to help direct the service. So, I recognise that it's a challenge and I won't tell you now that there is a single answer, because there isn't. That's part of the evidence we want to understand about is there a way that we could or should mandate, or do we need to tolerate a level of difference within the system. And that is always a challenge, you know—

[54] **Suzy Davies**: I take your point, but difference within the system is one thing. Following the money and making sure that those who take responsibility for employment, regardless of who they are, have minimum standards, requirements, qualifications and so forth—are you able to do that? And is it your role to do that, actually, or should that be something health boards do?

[55] **Vaughan Gething**: Well, each individual healthcare professional has individual responsibilities, and the people employing them have responsibility for oversight and making sure that they're able to maintain their professional competence. This isn't a new challenge. If you're employed by a practice and you are an individual healthcare professional, actually, your ability to talk to other healthcare professionals in your own professional group—the ability to get the leadership and the ongoing training and support—is part of the challenge that individual practices have in any event. There is an added element of 'How do we do this now?' when you're bringing together groups of people to work together. So, I'm not going to try and pretend to you that there is a single answer. I understand completely why lots of people would prefer to be employed by the health board as the host employer, and actually that isn't just the individual alternative healthcare

professional. Often lots of GPs want the person to be hosted by the health board because there's the element of management time, as the employer, if you're employing directly another member of staff that may be hosted with you but working across the cluster. So, I recognise the challenges are there but you get differing views on this. So, some people want to directly employ them within the cluster, within the federation, and other people definitely don't. So, that's why we need to be able to take a step back and say, 'What do we think is the right answer, the best answer?' Do we need to try and say we will mandate a way in which this will work and in which case will cut across people who are directly employing those staff now? Or do we say, 'Look, here's some guidance on, some evidence on, what appears to have worked and the views of people' and then people make choices? That's part of the challenge that we have, because I know, often, we'll get questions going in both directions, with the one person saying, 'Let these people innovate and don't get in the way. Don't tell them how they must or may employ people', and other people saying, 'You should tell them how they will employ people, not give them a choice, because there's an answer here that is the right answer for the system'. We don't yet, I think, have an evidence base to definitely say, 'We will say, "Do what you like. Get on with it. We're not worried about where they're employed in it", or, equally, if we're going to say, "Everyone should be, or must be, employed by the health board".'

[56] **Suzy Davies**: Well, my question was more about minimum standards rather than particular systems and frameworks, if you like. But apart—

[57] **Vaughan Gething**: They'll all have minimum standards, though. You know, there are minimum standards for employers—

[58] **Suzy Davies**: But who checks that? That's my question. Because this is new money. Presumably, you want to make sure that it's being spent appropriately, even if it's spent differently.

[59] **Vaughan Gething**: But if you're employing another healthcare professional, there are responsibilities for you, as the employer, and that individual healthcare professional has their responsibilities as well. I don't think it's my job, as a Minister, to go in and say, 'I am going to go and check that you are meeting your own individual healthcare professional standards that individual registrants are responsible for'. There's something about how far and how deep you want to get into this. Should we get that deep into it, actually, we're going to spend quite a lot of Government time and money doing that as well, and I'm not persuaded that that in itself will be a great

use of our time and public money, when we have other questions about process and outcomes.

[60] **Dai Lloyd:** Cyn inni symud ymlaen, mae gan Dawn gwestiwn atodol ar y pwynt yma. Down ni'n ôl wedi hynny, Suzy.

Dai Lloyd: Before we move on from this point, Dawn has a supplementary question on this. We'll come back afterwards, Suzy.

[61] **Dawn Bowden:** Thank you, Chair. It's just a technical issue, actually, Minister, and it probably goes back to when both of us had previous lives, when we used to look at employer-employee relationships. Actually, it is hugely important, and I'd be interested in your view on this, to identify who—for legal reasons—the employer is, because there are examples, for instance in schools, when governing bodies employ staff but actually the local authority is the employer but the governing body makes all the decisions about what they do. That's a similar kind of situation, so my question really is: for simplicity, would your preferred model be that staff are employed by the local health board for pay and rations and the clusters actually determine and direct the work? Particularly if members of staff are working across clusters, that would surely be a more sensible approach.

[62] **Vaughan Gething:** Well, if staff are working between different clusters, you can understand why it would make a lot more sense for them to be employed by a health board, practically, for the individual healthcare professionals, but also the clusters' point of view. Look, if it were me, I'd probably want the health board to be the host employer. If I were directly working in a cluster I'd probably say I'd want the health board to be my employer. But there's got to be a recognition that for some clusters they will want to directly employ staff, and they may have the legal setting to be able to do that and to discharge that responsibility effectively. That's why I say—. I won't tell you that I have one single view that I want everyone to deal with. Instinctively, I would prefer people to be employed by a health board. I'm not saying that means anyone else is not allowed to do anything else. We need to take a step back and look at what is happening. Is it really delivering the quality of service we want and providing employers and their employees with the sort of standards of employment we'd want to have as well?

[63] **Dai Lloyd:** Symud ymlaen. Suzy—mae Caroline eisiau dod i mewn hefyd, so Suzy, caria ymlaen.

Dai Lloyd: Moving on. Suzy—Caroline wants to come in, too, so Suzy, carry on.

[64] **Suzy Davies**: This might be a quick answer, actually, because I was going to ask you whether you think there were problems with clusters, in particular getting professional indemnity—whether that would push them into making the decision, effectively, that they would prefer any new staff to be employed by the health board.

[65] **Vaughan Gething**: Indemnity is one of the reasons why some GPs say that they don't particularly want to be the direct employer of new healthcare professionals. But there's quite a wide-ranging indemnity conversation that is also about where are their responsibilities for staff working in their practice with their patient group, and there are challenges there about whose patient it is for individual professionals. But I understand the concern that is raised about who is responsible for which staff working and whether it's on an indemnity basis or whether it's actually about who is the individual employer. They are things that we are working through and looking at the evidence and what people are saying directly to us, because, again, different people take different views on whether they think their indemnity cover is there, whether there are risks they're prepared to take, and in all of this there's a risk. There's always a risk in employing different groups of staff to come in and work, but actually we think there's a bigger risk in not doing anything and sticking with a model that we think isn't going to work without the reform. That's why we have clusters in the first place.

[66] **Suzy Davies**: Okay, thank you.

[67] **Dai Lloyd**: Caroline, do you want to come in?

[68] **Caroline Jones**: Just a quick question, and it goes back a bit, in answer to one of Suzy's questions about how GPs were embracing the cluster model, and you did paint a very positive picture, actually. But, looking at Pen Y Bont Health, they said that the cluster model was frustrating for them, and they moved on to the federation, the first federation of Wales. So, could you give me why they weren't embracing it more, or what could've been done for them to embrace the cluster model more, before moving on?

[69] **Vaughan Gething**: I think that goes back to the challenge about variation that exists, because you have individual groups of people who do and don't—. You can't get away from the fact that these are human beings and sometimes they do and don't get on, whether that's groups of general practitioners, whether it's groups of other healthcare professionals, or people in health boards. Actually, Abertawe Bro Morgannwg University Local

Health Board recognised that they wanted to make more progress in primary care and, in particular, on developing clusters. They actually acquired someone from Aneurin Bevan Local Health Board to help them to do that, because they thought that Aneurin Bevan were further down the road in delivering that. So, they actually got someone to help deliver a different approach in terms of the health board's own ambition. And I think that's quite encouraging, that they wanted to set a greater level of ambition and expectation. We have a federation in Bridgend, we have a community interest company in southern Powys, we have other developing talks with other groups of GPs who are talking about what are those models that they want to go down and how do they interact with clusters themselves. I wouldn't say that the experience in Bridgend means the cluster model is a failure. It's really about how do we make a cluster of primary care professionals effective with and for that local population so they can actually meet their needs more effectively.

[70] **Dai Lloyd:** Ocê. Yn ôl i Suzy. Mae gyda ti gwpwl o gwestiynau i orffen. **Dai Lloyd:** Okay. Back to Suzy. You have a few questions to finish on.

[71] **Suzy Davies:** Just on this question of different versions of clusters, and, in fact, multi-disciplinary teams as well, have you had any evidence yet that some of the new employees are actually being employed as managers of clusters so that GPs aren't being asked to themselves assume a management role that they didn't want before?

[72] **Dr Lewis:** Yes. Over the last 12 months—. I did a survey when I started the role about 12 months ago to see the range of cluster leads that were in place, the extent of multidisciplinary content of clusters, and, over the last 12 months—. First of all, we had some cluster vacancies 12 months ago. We now have no cluster vacancies across Wales, which I think again is an indication of people's support for the programme, otherwise we'd probably be having less. In terms of cluster leads, we now have some nurse leads, we have third sector leads, lay leads, pharmacy leads, public health leads and practice manager leads. So, there is a variety of—. Predominantly, we still have GPs as cluster leads, but there is evidence of newer roles being part of that.

[73] Also, in terms of the multidisciplinary content of clusters, we've now moved from 64 per cent to 80 per cent having a broader range of primary healthcare team membership over 12 months. So, we are moving in the right

direction. Also, it's pleasing to note that we've got more clusters with local authority representation on them, in terms of making those moves to work with local government, and also increased number of clusters with third sector and lay representation as well. So, it's, again, early days, but it seems as if the trend is that we're moving in the right direction to truly primary care clusters, rather than just GP clusters.

[74] **Suzy Davies**: Okay. That's what I was going to ask, about trend, really, because there's no point trying to relieve the workload of GPs with patients if they're going to end up with more management responsibilities. Bearing in mind that some of the GPs we're talking about weren't early adopters, going back to my first question, is this a trend you're spotting, or is this just good news for today?

[75] **Dr Lewis**: No, this is a trend over 12 months, and, certainly, I've met with both local medical committees and cluster leads across Wales over the last 12 months, and there is increasing engagement with, and positive feedback. While people raise concerns over pace, and the extent to which things are moving forward, there are various degrees of support from health boards in terms of that management support, which reflected where some health boards were at the start of the programme. So, some had already multidisciplinary community groups working on the primary care agenda. So, it's not just a sort of a spot, 'This is good news at the moment'; this is a 12-month comparison that also built on my contacts with lots of cluster groups across Wales.

[76] **Suzy Davies**: So, it is across Wales. It's not in specific health board areas—

[77] **Dr Lewis**: No. Some health boards underneath those all-Wales figures are doing better than others. And, from my role recently, the challenge to directors of primary care and to health boards is how they build on—. So, where certain health boards have maybe not got as much local authority representation across their clusters, or lay representation, what actions are they taking to encourage that by talking to clusters? And also that's part of my role in terms of encouraging cluster leadership and health boards to support that multidisciplinary content, so that they are truly looking at an integrated system, not just from a GP viewpoint.

[78] **Suzy Davies**: We look forward to talking to you in 12 months' time on this and to see if it's worked.

[79] **Dr Lewis:** I'm happy to talk at any time.

[80] **Suzy Davies:** Just a final operational question, which is about accommodation, effectively: what sort of feedback have you been getting from any clusters about their ability to accommodate multidisciplinary teams? How innovative are they being on that?

[81] **Vaughan Gething:** There's an ongoing challenge about remodelling our primary care estate, because different parts of the estate are in better or worse conditions. We'll all be familiar with the times of the past where, effectively, a house is converted to become a GP surgery, and a recognition that those facilities need to change and move on. And, actually, there are challenges about the previous ownership model—who owns the building when new people come in? So, I expect that we'll continue to see—and you've seen some of our budget choices are about trying to reserve some capital for primary care—that that remodelling of primary care will be about trying to build that broader multidisciplinary team.

[82] So, you'll see a different pace in different parts of the country, depending on who the partners are. For example, we know that, on occasions, local authorities—.

10:00

[83] In Cwm Taf, for example, they have a very good relationship with their two local authorities, both in the way they plan their services—so, the neighbourhood planning for local authorities matches the cluster footprint, and that's been really helpful—and they have a really constructive relationship about making use of the public estate between the two of them to try and remodel primary care within that area. I think there's not just local authorities, but also housing providers as well, about opportunities, thinking, 'How do you deliver new facilities and services where they're needed?', because I wouldn't think there's a single one of us in the areas that we represent individually that would say, 'Actually, there are no challenges at all on the estate that exists within primary care.'

[84] So, it's a national challenge. It's been brought into sharper focus by wanting to have teams work together and wanting to house teams together if at all possible. But I think that, over time, we'll see the estate being shifted to accommodate the remodelling of primary care. Prestatyn is a good example,

actually, of that happening—a challenge of actually needing to maintain the service, but actually the remodelling has also gone along with looking at how the estate is used to positively remodel the service and provide a better and wider service to the local population.

[85] **Suzy Davies**: I'm sorry, just before you come in, just generally, are clusters free to acquire estate of their own if they choose to do so? Obviously, there's a huge financial cost to them. I'm just wondering if there's anything preventing them.

[86] **Vaughan Gething**: If a group of people wanted to acquire something together, they could do that.

[87] **Suzy Davies**: Okay, that's all I wanted to know.

[88] **Vaughan Gething**: For example, the federation in Bridgend could decide that they collectively want to purchase a building.

[89] **Suzy Davies**: Okay, that's what I wanted to know.

[90] **Vaughan Gething**: The challenge will be in planning, and there's the attitude to risk in doing that, though, as well, which is part of the reason why we see some of the challenges we do with the old estate that we recognise is no longer fit for purpose. If you own that and that's part of what you own as an individual professional, if you're a partner in a practice, to move into a different building, there's a challenge about who takes the risk for that. And if the public purse is going to provide a new building, then lots of people here would expect that the public purse would need to own the freehold of that building as well. So, we've got to think about how we remodel primary care and, actually, how we think about all the different liabilities and responsibilities that people running GP surgeries, in particular, have now and what that means for a newer generation of healthcare professionals, not just GPs, coming in and wanting to work in the service. So, it's not—the problem is easier described than the answer.

[91] **Suzy Davies**: I was just checking there was no legal limitation, that was all. I didn't think there was. But anyway, sorry, you were saying, Dr Lewis.

[92] **Dr Lewis**: There are some examples of some practical initiatives already. Some practices, particularly, I think, in Hywel Dda, but across the piece, have got a lot of rooms still taken up by paper records. There is a

rolling programme of digitalisation of records to free up spaces in practices, so some immediate—apart from the long-term estates—sort of ideal. Also, some of the benefits of working at scale, such as in Neath, where some of those staff are working not in any of the practices, but on a different site, or where one practice has got more room than others and they're using their accommodation to provide those staff resources to others in that cluster arrangement, because some practices would be too small to justify or be able to accommodate some of those roles. So, there are early practical solutions coming forward, as well as the need to look at the longer term estates challenges.

[93] **Vaughan Gething**: To be fair, that collaborative approach wouldn't have happened without cluster working bringing people together and actually making sure that different healthcare professionals talked to each other about what was possible and why, because, you know, that wasn't happening 10 years ago. There is a conversation about the better use of their estate and their premises now, and cluster working is promoting that. So, it's a fringe benefit, if you like, but it's an important signal of the fact that there is a different way of working that people are buying into.

[94] **Suzy Davies**: Thank you. Thank you, Chair.

[95] **Dai Lloyd**: Mae'n amser i ni fod yn cerdded ychydig bach yn gyflymach, ac rwy'n edrych ar Huw a'i aeddfedrwydd a'i brofiad dros y blynyddoedd. Mae'r cwestiynau nesaf o dan dy ddwylo di, felly, ar heriau'r gweithlu presennol ac i'r dyfodol. Huw.

Dai Lloyd: We need to move on a little more quickly, and I'm looking now at Huw and his maturity and experience over the years. The next questions are with you on the current and future workforce challenges. Huw.

[96] **Huw Irranca-Davies**: Diolch, Cadeirydd. Could I ask you—we're very aware of the acute existing pressures on workforce, right across the sphere within healthcare, but also future issues as well—does cluster work and multidisciplinary working help alleviate those pressures, or does that exacerbate those pressures?

[97] **Vaughan Gething**: The majority of the feedback that we have is that cluster working and multidisciplinary working make it more attractive, for GPs in particular, but also for other healthcare professionals too. If you talk to allied healthcare professionals, they'll say they want to be part of

delivering this work as part of a wider team. And if you talk to GPs about the change in their workload and the way in which the work has been moved around, actually, the great majority of them are positive about it and say, 'This is the future'. This is what they want the future to be, and it's then about how we're able to deliver that.

[98] That goes into training as well, actually—the training environment. So, both people in the service now, who've been used to working in a different way, as well as new people coming in, in particular in Swansea and Cardiff, but also in other centres where other healthcare professionals are trained—that that reflects the way that we expect them to work in real time and real life when they're actually out and working within these larger and wider teams.

[99] **Huw Irranca-Davies:** And how do you respond to some of the evidence that we've received that suggests that one of the dangers is the creation of an internal market competing for the same—not simply GPs, but allied professionals, that range of people that you would have working within clusters in multidisciplinary teams? It's actually establishing now an internal market where there's competition between different areas for the same people. So, it might be making it more attractive to work in clusters, but you're pulling it away, perhaps, from secondary care or elsewhere.

[100] **Vaughan Gething:** Well, there's an honest challenge here about how we get our whole service to plan and work together, so that you're not pinching from different parts of the service and just shifting different pressures around, but actually—. For example, if paramedics are going to be part of the answer in primary care, then rather than them being taken away from the Welsh Ambulance Services NHS Trust altogether, it's about trying to work out how those people can work on a rotational basis. And it's also then about making sure that they maintain skills in different parts of practices.

[101] We see there, for example, an active conversation in Aneurin Bevan, but also in and around Anglesey as well, and Gwynedd, thinking about how you use some of the advance paramedicine practitioners to do some of that work. That's part of the conversation that we expect people to have. It is part of our expectation of being a small country and then having enough people to be able to sit down in the same room to talk through and agree on some of the challenges rather than simply going about saying, 'Well, I'm prepared to pay more', because otherwise we end up driving costs up in a way that doesn't necessarily deliver a better service.

[102] **Huw Irranca-Davies**: So, on that basis of being a small country where we are able to have some clarity on making these system changes, I assume you would accept that this will need some new skill sets, both in terms of identifying some professional discrete areas that we need to infill, but also that issue of working across, as a part of multidisciplinary teams. Who's leading this at a national level? Who's leading this at local health board levels?

[103] **Vaughan Gething**: Well, you've got teams both within—. Well, you've obviously got workforce and operational directors within each of the health boards. You've got a team here that look at that as well. There are conversations that take place at that level, but also with partners in any event, whether it's in the ministerial taskforce that I lead or whether it's in the partnership working that we have across the service as well. One of the Members in this committee used to be part of those arrangements as well, talking about how these challenges are recognised and then how they are resolved. Part of the way we want to work is actually about saying, 'We will have a conversation'. It won't always be about there being a ministerial mandate saying, 'You must'. There are times when that might be necessary, but, actually, if you broadly run your system by shouting and demanding all the time, then you tend to get a smaller return.

[104] **Huw Irranca-Davies**: But I think—and this could just be a 'yes' or 'no'—you're confident that both at a national workforce planning level here within Welsh Government and with its partners, but also at a local health board level, they're seized of the necessity of not only meeting current and future, broadly, challenges for the workforce, but also the challenges of moving towards this more multidisciplinary approach. You're confident, as a Minister, sitting here—I appreciate you can't micromanage—that this work should be going on, but is going on within local health boards.

[105] **Vaughan Gething**: Yes, and it's always about how successful it is. There's a very clear recognition that the work needs to take place on, for example, some of the ways in which we're going to plan and deliver our workforce in the future, whether it's about Health Education Wales, or about the way in which different bodies will work together, or whether it's about expecting health boards to sit down together and plan their services across health board boundaries. Yes, that work is taking place, but that isn't just going to be about planning secondary care. It's absolutely going to be about the primary care workforce too.

[106] **Dai Lloyd**: Diolch yn fawr, Huw. Rydym ni'n troi rŵan at faterion cyllidol, ac mae'r cwestiynau nesaf o dan ofal Dawn Bowden.

Dai Lloyd: Thank you very much, Huw. Turning now to funding issues, Dawn Bowden has these questions.

[107] **Dawn Bowden**: Thank you, Chair. We've heard about the benefits of local developments within clusters and the potential for doing things differently. That's what we would expect. We've got 64 different clusters, so, clearly, one size isn't going to fit all. But, are you satisfied that the way in which the money is being spent in the clusters is proving to be delivering value for money at the moment, bearing in mind that, by the very nature of the clusters, they have to do things differently, or is there a danger that the spend can be a little bit ad hoc?

[108] **Vaughan Gething**: Part of the demand, from my perspective, is (a) to demonstrate the money is being spent, but also, as we go through, demonstrating the value of that. Going back to, if you like, our first conversation about evaluation and being able to demonstrate impact and what that money is doing, I don't have concerns that are brought to me by individual stakeholders that money is being spent poorly. More of the concern is: are we spending the money at the right time and are clusters actually getting the opportunity to spend that money in areas where they think it'll make a difference? It's about the relationship between health boards and clusters, as that's been developing and maturing, on being able to make choices with that money and making sure that money doesn't disappear from primary care if it isn't spent in one year, which is a concern that individual stakeholders have brought.

[109] So, when I meet vice-chairs—and I'm meeting vice-chairs next week—I regularly ask them, 'Where's the money? How's it being spent? Tell me about it'. There's got to be accountability at the board level, about if they're not spending their money then why and what are they going to do about it, rather than just saying, 'Oh well, you've given me a figure and that's okay', because that isn't going to be acceptable. I think vice-chairs and boards do understand that they have to be able to demonstrate that, because the last thing I want is for a cluster to be able to point to a sum of money that could've been spent but, for some reason, it hasn't been released, because, you know, this money is there for a purpose.

[110] **Dawn Bowden**: One of the problems that we have heard is that there is

sometimes a bit of a time lag and a delay in getting the money out from the health boards to the clusters. Is there a way in which the system can speed that up, or is this just the way in which the finances are allocated—that that just happens to be a problem that we can't overcome?

[111] **Vaughan Gething:** I'll ask Grant to come in in a minute, but, look, in the first year, you can understand how, as you get things set up, it's more difficult to spend all of your money within the year. All of us understand, not just from life here, but outside as well, that getting a sum of money in one year and being able to spend it all in that year—. If it's on staff, you've got to recruit them, you've got to bring them in and, often, there is a lag in getting those people in and, actually, in getting people moving at different paces to agree on what those priorities should be as well. So, we understand some of those delays.

[112] As we get into the second and the third year, that explanation becomes less and less acceptable, and less and less real. So, that's why there isn't going to be a tolerance for that as an excuse for why money hasn't been spent. But, there is real oversight and there is real demand, both at board level, but also in Grant's relationships directly, and the demand with health boards as well.

[113] **Mr Duncan:** I think it's both. I think, as the Cabinet Secretary has said, sometimes, when it comes to recruiting, the recruiting timescales can be perceived to be quite long, but once the pipeline is filled, then that should get faster. There is also a variety—as there are clusters of various maturity, sometimes they haven't decided quickly what their actual priorities should be. Then they look back and say, 'We haven't had the money', but it's with them in the first place. So, there are those tensions. The work that I do with the directors of primary care is continuing to challenge this. It's not necessarily easy all the time to say, though—this is the thing—but I think the feeling is that it is actually getting better. But there are areas we still need to be pushing on, and we do.

[114] **Dawn Bowden**: Can I come back to a point that the Cabinet Secretary made earlier, because I think it links in with this? We did hear quite a bit of evidence about the frustration of clusters not being able to spend their money in the year in which it's allocated for reasons outside of their control—the kind of things that you've been talking about. The appointments process might take longer than they would've wanted, because it's controlled by the health board, et cetera. If they don't spend their money by the end of

that year, then they lose it. They've said that that is a huge frustration for them, whereas health boards have the ability to roll over their finances over a three-year period now, and whether you could look at allowing them, where there are those sorts of circumstances, where they've underspent, to roll over their finances into the following year so that they don't lose it.

[115] **Vaughan Gething:** We've made clear that we expect the money to be re-provided, which isn't quite the same as rolled over, but we expect that money to be re-provided. So, when I talk to vice-chairs about the money being spent in clusters, if they're not spending, particularly if the sum is significant, then I'll expect the health board to re-provide that money for clusters to use in the next year.

[116] If I were a cluster lead and I said, 'Look, we have a project that we thought we'd signed off and agreed, but, for some reason, the money wasn't available, there was something else that stood in the way, and I'm now told I need to manage with less next year', you know, I think I'd be complaining about that too.

10:15

[117] So, we've said we expect the money to be re-provided and we expect health boards to be able to achieve that within the significant resource envelope that they get each year.

[118] **Dawn Bowden:** Because I think there is a concern that some of this money is being used to prop up shortfalls in health boards, and so the clusters are not getting the benefit of it. So, you can assure them that that isn't the case.

[119] **Vaughan Gething:** Yes. We've had that directly from stakeholders asking that question, and I've said that money can only be spent in primary care; you can't put it into the bottom line. That isn't what the money is there for. And for those health boards that aren't living within their means, pinching money from clusters isn't a smart or acceptable way to try and resolve their bottom-line issues.

[120] **Dawn Bowden:** So, it's ring-fenced. It should be ring-fenced.

[121] **Vaughan Gething:** It has to be in primary care. It hast to be spent on primary care.

[122] **Dawn Bowden**: Okay. My final question then, Chair, is around the short-term nature of the moneys, and whether that in itself actually prevents the kind of innovation that it was intended to deliver. You've already talked about the fact that the large amount of cluster development money goes on staffing, which is inevitable, I guess. That in itself shouldn't prevent innovation, because staff themselves should be the innovators, shouldn't they? So, I don't see the spending on staff necessarily as being a—. But is the short-term limited nature of it a potential problem to that sort of innovation?

[123] **Vaughan Gething**: When we start—[*Inaudible*.] We were just talking earlier about the evaluation and needing to understand at the point of evaluation what we think we could and should do for the future. But, there's going to be no—from my point of view—walking away from clusters. The idea that we'd say, 'We don't think clusters work so we're going to break them up and start them again'—I think that'd be hugely disruptive and the wrong thing to do for staff and the citizens who rely on the service. So, it's about how we make clusters work, not about saying we're prepared to tear it all up and start again. And if the money is there—and we've said there'll be money for clusters each year, so people should be able to plan on that basis—there is then this conversation between clusters and health boards about what becomes mainstream and what becomes mainstream funding, and the evaluation should help us with that as well; about understanding what we think should be mainstream provision. And there's a challenge about how you recycle money to keep on being able to innovate—do you say 'We've spent all the cluster money, we're carrying on spending it the same way, and so that's it. That's the end point of innovation in clusters'? Well, I accept and I recognise your point that, actually, staff should always want to be innovative in how they use the resource they've got, but that's part of the challenge of what becomes mainstream and why, and then how do we get to the point of understanding what that should be and what that means for health boards and them managing their resources. But, we always talk about the shift from secondary into primary care, and I've said consistently to stakeholders in private meetings, and in this setting as well, that the money needs to follow the service. And if you're moving services around and there's a need to spend money differently, you need to spend that money differently, rather than simply saying there's a big fence between secondary and primary care and you're not allowed to see money moving between the two even as a service and the way it's delivered changes as well.

[124] **Dawn Bowden**: That makes absolute sense. I think that brings us—this

is a final point, Chair. Just following on from what Rhun was saying earlier on in terms of evaluation—because some of the evidence that we've heard was concern around maybe mental health services not getting their fair share of the CDMs in the clusters. Again, presumably—or you'll tell me if not—that's something that you will be looking at in terms of your evaluation, that all services that are being delivered by the clusters will be getting their fair share. Otherwise, it's not going to work, is it?

[125] **Vaughan Gething**: Well, there's something here about each cluster together being able to plan for the needs of the local population. So, they will make slightly different choices. Not every cluster has got a physiotherapist or a pharmacist—most have. But, look, there's something here about how do you then—. There's the accountability of that money, as well, about why those choices have been made, how that fits health need. But in lots of the—. In fact, in the areas that I see, each of those groups have talked about the need to deal with some of the mental health challenges that exist, whether it's about social prescribing, whether it's about bringing in a counselling service—we saw that in Brecon, in Barry and also in the Neath group as well—but they recognised there was a need to do it. And it's one of the three priorities for the directors of primary health and mental health moving forward, as well. They recognise a need to improve this area of practice. It isn't just about the measure and the local primary care service that exists, but actually about recognising that this is an area of real pressure that's going into primary care and the time that it's taking for a GP as well, and how they have an appropriate route to help people to move into a service—whether it is counselling, whether it's social prescribing—to make sure this is part of what is readily available. So, again, when we have our evaluation, I would expect to see a significant part of that being what is already happening in dealing with that mental health challenge and whether we think it is enough. And if it is, we will think more people should do it. So, you can expect to see more of that in the evaluation coming out in the spring, yes.

[126] **Dawn Bowden**: Okay, thank you. Thank you, Chair.

[127] **Dai Lloyd**: Before we move on, can you just confirm, as regards cluster underspends, can they be carried over to the next financial year?

[128] **Vaughan Gething**: We expect them to be re-provided. We expect health boards to re-provide them from within their resource envelope. That's slightly different to saying the money is just rolled over and protected and kept over, but our expectation is that the money will be re-provided in the

next year, and money spent within that year has to be spent on primary care. So, it can't go from, 'We haven't spent it on a cluster this year, so we'll put it into the bottom line'. That is not what we've said is going to be acceptable.

[129] **Dai Lloyd**: So, the sort of panic feeling within a cluster to spend, as well, or to actually get things in—there should be no panic, then.

[130] **Vaughan Gething**: We don't think so, but that's also part of making sure that there's a proper relationship between the cluster and the health board. There should be a proper grown-up conversation between professionals working in a cluster and within the health board about understanding—to make sure they're getting real value from the way they spend their money, rather than simply looking to get money out of the door before 31 March. We recognise that lots of people spend money poorly if they are just looking to burn money and get it out of the door before the end of the year. That's not a helpful way to run this service or any other part of public or private service as well—I'm thinking about my previous life in a different employment setting.

[131] **Dai Lloyd**: I symud ymlaen, mae'r cwestiwn nesaf o dan ofal Lynne Neagle. **Dai Lloyd**: Moving on, and Lynne Neagle has the next question.

[132] **Lynne Neagle**: Thanks, Chair. The committee hasn't had any hard evidence that clusters are actually doing anything systematic to tackle health inequalities, but rather that the money is just being allocated across GP practices in a very general way. Is that a view that you recognise, and if it is, what more do you think should happen to ensure that the clusters are actually targeting resource at the areas of highest need?

[133] **Vaughan Gething**: Well, part of what we've done in creating these is that groups of health professionals can come together to plan their service to meet the needs of their local population. It isn't simply about splicing up the money to make sure that each GP practice can say, 'We've got a share of the money'. It's actually about how you meet the need within that population. There is more than just one GP practice area. It's also why we say that they're primary care clusters and not just about GPs sitting down and agreeing with each other how they will spend their money. So, when we talk about mental health services, it's because people recognise the need that comes through the door, and that does. That need exists across the country. It also differs depending on the group of the population that they're dealing with. It's also

why cardiovascular risk assessments are taken forward in some parts of the country at a greater pace, because, actually, that's a greater need within that population and we know that there is a definite relationship on a range of these areas with socioeconomic inequality as well. But, again, I expect to see coming through from both the informal evidence base that we have and the anecdotal evidence base—but then the evaluation as well—about telling us: do we think we are making the sort of differences that we want to, and need to, in addressing health inequalities?

[134] It isn't just this area, of course, because the programme that's been rolled out recently in Huw Irranca's constituency, having started in both Aneurin Bevan and Cwm Taf—Living Well Living Longer it is called in Aneurin Bevan. But that is proactively going out and looking at parts of the population that aren't regularly engaged within healthcare services. That doesn't rely on the cluster programme, but that does rely on actually having a programme that is working out within the clusters and will be more effective to roll that service out in the way that those healthcare support workers are deployed across that wider community that exists. So, it can't just be about individual practices. Otherwise, I think we'll use the money poorly.

[135] **Mr Duncan:** There is also, I think—. One of the control mechanisms is the actual role of the health boards. The tension is: the advice is to be light touch in terms of engagement with the clusters and the clusters' money, but the health boards are still finally accountable for it. They'll need to have sight of the plans to check that, actually, it's not just about fair fees for GP practices and that it's actually targeting legitimate activities. The other area is that the actual GP contract helps specify, in terms of the issue of the new contract, different engagement in different national priority areas. So, it says that the clusters must agree—each one must agree—a locally agreed priority area and choose two from a basket of five national ones, such as mental health, dementia, COPD, liver and cancer. So that helps focus in on what the clinical priorities are within the area, as part of the cluster action plan, which they must agree.

[136] **Lynne Neagle:** But health inequalities, as you know, is about more than just targeting particular conditions, isn't it? It's about recognising that in communities with high levels of deprivation, there is going to be a higher prevalence of illness across the board, really. So, are you saying that GP clusters are actually making that decision to put more money into those areas? That means some practices losing out, then, doesn't it, saying 'I'll

have less money because this areas needs more money.' Is that happening?

[137] **Vaughan Gething**: There is some evidence of that happening. For example, the way in which services are based and how they're targeted. So, it isn't just about saying—. Going back to the starting point, it isn't about everyone saying 'I must have my share' rather than saying, 'At a cluster level, where are our health needs and how do we address those health needs?' And that means behaving differently in different communities and recognising need. Richard's got some examples, but we do know that that is happening. It's really about whether we'll able to see, when we take a proper step back: is that happening at the level that we want to, and are we able to demonstrate that in the way that those clusters deal with that? But some of these clusters will be, broadly, groups of practices where, in some parts of the country, they'll all have a level of deprivation. With the ones in the city centre, for example, here in Cardiff, there'll be differing levels of deprivation. The south and central will have some relatively affluent parts of the city of Cardiff, and some very poor parts. And so, we'll see that in the different clusters that we have around the country.

[138] **Dr Lewis**: As part of the cluster evaluation of the initiatives that they want to take forward on a population level, health boards are tasked, through the local public health function, to provide that population information, and therefore, to raise with them where deprivation and inequalities of health are impacting on the services, apart from what they know themselves anyway, and to make their funding or cluster initiatives based on that. As well as that, under the programme, at least two health boards that I'm aware of—Aneurin Bevan and Cwm Taf—have specific inverse care law initiatives that are looking specifically at health inequality issues. So, there is evidence there, but it's based on local population information that's being provided to clusters to help them to make that decision. Also, to aid that process, by, I think, the autumn, two thirds of cluster leads in Wales will have gone through a confident leaders programme, and part of the component of that is understanding population health measures, supported by public health colleagues, so that they are increasingly taking those sorts of issues on board in their decision making.

[139] **Lynne Neagle**: Thank you.

[140] **Dai Lloyd**: Troi rŵan at yr adran olaf o gwestiynu. Mae'r rhain ar aeddfedrwydd ac arweinyddiaeth,

Dai Lloyd: Turning now to the final section of questions. These are on maturity and leadership, and Jayne

ac mae'r rheini o dan law Jayne Bryant has these questions. Bryant.

[141] **Jayne Bryant**: Thank you, Chair. You've said that we're early in the journey on this, and clusters are at very different stages around Wales, but also within health boards. And we've heard from some witnesses that there is a need to ensure better shared understanding about the role and purpose of clusters. I know you've said that you don't want to be overly prescriptive, but how can you ensure this will happen to maximise the benefit of cluster working?

[142] **Vaughan Gething**: There's a range of different ways to do that. It's about accountability in different bodies at different levels. So, Grant and Richard engage with different groups in the service. We've got Grant dealing with the directors of primary care and the messages that they directly get from him. Richard goes out and talks directly to lots of groups of local clinicians around the country, as well as having the role in here as well. I go out and I have sat and met people in cluster groups as well in some of those meetings, to directly understand what's happening. And there's then a shared learning. So, that's partly about the evaluation we talked about, it's partly about what happens in the ministerial task and finish group, but it is also about the reason why we're having another national primary care event in October, to see how much further progress we've made, so that people do understand the ministerial priority that this is an area of real importance. And there'll be an expectation, when they come to that event, to be able to describe the progress they've made, and also to be able to set out what they expect to do in the future as well.

[143] Actually, at the first event, I was genuinely encouraged by the fact that people were sharing what was happening and looking critically and positively at what they were doing compared to what other groups were doing as well, and not just the health boards, but also Public Health Wales and the Welsh ambulance service trust in particular as well. So, again, that goes back to having a small country and being able to hold a genuinely national event, where that shared learning can take place. The confident leaders programme is part of that as well, because you draw together cluster leads from different parts of the country, who are taking on real local leadership responsibility, and again, they're looking critically at what they're doing.

10:30

[144] People often find they have the same challenges, and there are times when there are uniquely individual ones. But it's partly about how we draw different people together but in a way that adds value. So, I can turn up and say, 'I've had a national conference', but, actually, there's real value from the event both for me but also from a system point of view about being able to reset our ambition and make sure there is real learning that takes place not just at the event, but moving forward as well.

[145] **Jayne Bryant:** Thank you. We touched on this earlier, about leadership being key to this, and some witnesses have argued that there should be less health board involvement and more autonomy for clusters. Perhaps you could elaborate a little bit more on that.

[146] **Vaughan Gething:** That goes back to some of the challenges we've had about where is the national 'you must' or 'you should', and where is the 'it's up to you locally to make choices'. You heard from Grant earlier about people choosing their own local priorities, but also having a basket of areas to prioritise as well in the cluster development plan moving forward. So, there's a tension here, in that we can either say, 'We will tell you what to do all the time', but, actually, I think we'll lose a lot of the buy-in that we've engendered by people recognising they can make their own choices, and they can make their own spend decisions about the needs of their local population as they see them and as they are currently seeing them come through doors in varying parts across their clusters.

[147] That goes back to both national and local leadership. It goes back to the local leadership between health boards and having a genuine and a grown-up, constructive conversation with their clusters, and about working together with them. It also goes back to those cluster leads themselves being able to exercise and demonstrate that local leadership with their local populations of healthcare professionals, because, to be perfectly honest, not every group of practices started this in a particularly willing position, and you will find differences of opinion. That shouldn't be a surprise to anyone. It's not a criticism; it's a recognition of the reality of human behaviour. But that local leadership is really important with those other healthcare professionals.

[148] It's also really important with the local population, so that they understand the change that is taking place and that reform is for a purpose, and it's about how we improve the healthcare delivery and the experience of

healthcare that they have, rather than simply about, 'It allows us to fill out forms here'. It must be about very real and practical change. And that's why I understand we'll talk about evaluation and we'll talk about patient experience—and I'm sure you'll want me to talk about this again in the future—but this has to be real, and we can't do it all by three men in suits on a national level standing up and making speeches. However good those speeches are or aren't, it's got to be delivered with local leadership as well.

[149] **Jayne Bryant**: Do you think there's a danger, though, that cluster development is too reliant on individuals to drive change locally? How do you see that? How can we affect that?

[150] **Vaughan Gething**: That's part of the reason why we've drawn together those different groups of people to look at cluster development in different parts of the country, so that people aren't left on their own, because, otherwise, you would potentially have areas of excellence that are solely about inspiring individuals, and there could equally be areas that aren't making progress because you may say, 'That's about individual local leaders'. You've got to support those people as well as challenge them. That's why we have those differing groups. It's the confident leaders programme drawing those people together, because that's been really important. When I met a group of them as they were going through the start of the programme, it was really interesting not just to talk to them, but actually in the questions that came through and what their own feedback was then from the value of that programme, and how they see it as well. So, I'm genuinely encouraged by the greater level of buy-in that we are seeing, and the recognition that local leadership is starting to emerge on a more consistent basis. And I think we'll all be better for it.

[151] But, in particular, I think that local healthcare professionals should see that local leadership and recognise that as peers that they trust and value. It's also about that peer-to-peer challenge being a really important part of the improvement journey that we have. And it goes back to questions about inequalities and how they're dealt with, and about peer development and saying, 'Look at the need we have within the local populations that we all serve', or whether it is about how we are actually making smart choices about the use of other healthcare professionals to come in and help all of us to do our jobs more effectively. So, that exists. It's still about taking the evaluation reports and saying, 'Is it delivering what we want it to?', and that won't just be the formal evaluation; it will be about listening to people as we continue, because if our leaders—our cluster leads—are telling us consistent

messages, then we have to be prepared to listen and to be able to adapt as to how we want the programme to work in the future as well.

[152] **Jayne Bryant:** And, finally, do you think that the model of 64 clusters is right? Do you think that we're big enough as a country to have these 64 clusters to make sure that the range of service change needed happens?

[153] **Vaughan Gething:** The decision on choosing cluster areas was drawn on evidence from the King's Fund, amongst others, about the sorts of groups of population that you can plan for and deliver improvements for locally. It then has to be something—the proof of the pudding being in the eating—about whether these are the right number. Have we got the right groups of people drawn together? I don't see any reason at this point in time to say we need to interrupt the cluster map to try and draw things across different boundaries, because having set out a programme that we recognise is relatively early in its journey, I think, now, to start trying to interrupt and change those boundaries, we'd have to have a really good reason to interrupt the way they're working. As I said earlier, in some parts of the country—and this is a developing theme—local authorities are working with health boards and planning together locally on the basis of those cluster footprints. That's a really helpful development. So, if there was a really good reason, I wouldn't say, 'No, we'll never change it. Go away', but, equally, it would have to be a really good reason to want to change the maps and the groups of the population that we're drawing together to work in this way, because otherwise you'll have to restart some of that work and the relationships that are being developed across the country.

[154] **Dai Lloyd:** A oedd cwestiwn atodol gyda Dawn?

Dai Lloyd: Did Dawn have a supplementary question?

[155] **Dawn Bowden:** Thank you. I just wanted to go back to clarify something around who makes final decisions, because we had some conflicting evidence. You've talked about, and I think you've been very clear about the local priorities and local innovation for the clusters themselves, and we had health boards giving us evidence saying, 'Yes, absolutely, that's what happens', and the clusters sign it off, and they get the authority to spend the money, et cetera. The clusters, then, were saying, 'No, we don't get the final say. It's the health board that has the final say', so there was a direct contradiction in that, and I wonder whether they were actually talking about two different things. What is your understanding, and what is your view on what should happen once the clusters have decided this is how they

want to spend the money, this is the innovation, this is the priority? Should they be allowed to just get on and do that?

[156] **Vaughan Gething:** Yes, they've got to have a plan that works and makes sense, but it's their plan. It isn't for the health board to come in and say, 'We are telling you what you must do in every single area of activity'. Otherwise, it won't work. It's just a way of trying to direct the service, then, as opposed to getting people together to generally innovate and determine their own local priorities. Once they have that plan signed off, they should get on and make those choices, but they've then got to be accountable for the choices they've then made in terms of the spend of the money.

[157] I recognise some of the frustration that comes through about having money, and how quickly that money is spent. I think there's something real there in some parts of the country, and there's a need for improvement, but I don't really recognise the idea that people aren't allowed to spend money. It's a frustration at the speed with which that comes through as opposed to, 'We're not allowed to choose and determine our own local priorities'.

[158] **Dawn Bowden:** So, it isn't a question of the health board telling a cluster that they can't spend the money in a particular way.

[159] **Vaughan Gething:** No, because, at the end of the day, people choose their local priorities. There are baskets of areas to choose from. That's been negotiated with stakeholders, about what those areas should be, actually to say, 'Here are our local priorities, here is how we are going to deliver that'. But you expect there to be a conversation with the health board about the support that they may or may not need to provide. Then you have this dichotomy of, 'Leave us alone to get on with it', and others saying, 'We want you, the health board, to come and help us and support us in making these choices and support us in the spend of the money'. So, we're never going to get a perfect answer, because, as you know, the same people reflect the same conversation in different ways.

[160] **Dawn Bowden:** Okay, thank you.

[161] **Dai Lloyd:** Just to confirm, obviously we've had evidence that there are no published governance frameworks vis-à-vis the clusters, and also only three out of the seven health boards have published their cluster plans for 2016-17. Any thoughts about increasing the awareness of both frameworks and plans publicly?

[162] **Vaughan Gething:** Do you know where we are with the publishing of the plans, about when that should happen?

[163] **Mr Duncan:** On the publishing of the plans, the plans do exist—it's a question of reminding the health boards. I don't think there's any mandate they must publish them, but that's something that we can get back to you on.

[164] **Vaughan Gething:** Would it be helpful if we made sure that was provided to committee, for example?

[165] **Dai Lloyd:** Good. That's fine.

[166] Grêt. Diolch yn fawr. Nid oes yna gwestiynau eraill, nid wyf i'n credu. Dyna ni. A allaf i, felly, ddiolch i Ysgrifennydd y Cabinet, Vaughan Gething, am ei dystiolaeth y bore yma, a hefyd diolch yn fawr iawn i'ch swyddogion, Grant Duncan a Dr Richard Lewis, am eu presenoldeb a'u tystiolaeth hefyd? A allaf i bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau ei fod yn ffeithiol gywir? Felly, diolch yn fawr iawn i chi.

Thank you very much. I don't think there are any further questions. May I therefore thank the Cabinet Secretary, Vaughan Gething, for his evidence this morning, and also thank his officials, Grant Duncan and Dr Richard Lewis, for attending and for their evidence as well? I can confirm that you will receive a transcript of this meeting to check for factual accuracy. So, thank you very much.

10:39

Papurau i'w Nodi
Papers to Note

[167] **Dai Lloyd:** Fe wnawn ni symud ymlaen at yr eitem nesaf. Yr eitem nesaf ydy eitem 3, a phapurau i'w nodi. Bydd Aelodau wedi sylwi ar, ac wedi darllen mewn manylder, wrth gwrs, y llythyrau yr ydym ni wedi eu cael oddi wrth Iechyd Pen-y-bont a hefyd gan Goleg Nyrsio Brenhinol

Dai Lloyd: We'll move on to the next item. The next item is item 3, papers to note. Members will have noticed and read in detail, of course, the letters that we have received from Pen-y-bont Health, and also the Royal College of Nursing Wales, and the additional information from

Cymru, a hefyd y wybodaeth ychwanegol gan fwrdd iechyd addysgu Powys.

Powys teaching health board.

10:40

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[168] **Dai Lloyd**: Rydym yn symud ymlaen, felly, i eitem 4 a chynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. A ydy pawb yn gytûn? Mae pawb yn gytûn. Felly, fe wnawn ni symud i mewn i sesiwn breifat, a bydd angen symud y cyhoedd o'r oriel.

Dai Lloyd: Moving on, therefore, to item 4 and a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Are we all content? I see that we are all content, so we'll now move into private session, and the gallery will need to be cleared.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:40.
The public part of the meeting ended at 10:40.