Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

The National Assembly for Wales
The Health and Social Services Committee

Dydd Iau, 1 Mawrth 2007
Thursday, 1 March 2007

Cynnwys
Contents

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

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

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Brian Gibbons	Llafur (y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol) Labour (the Minister for Health and Social Services)
John Griffiths	Llafur (Dirprwy Weinidog) Labour (Deputy Minister)
Helen Mary Jones	Plaid Cymru The Party of Wales
Jonathan Morgan	Ceidwadwyr Cymru Welsh Conservatives
Lynne Neagle	Llafur Labour
Jenny Randerson	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Rhodri Glyn Thomas	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)

Swyddogion yn bresennol
Officials in attendance

Ken Alexander	Y Gangen Gwella Ansawdd a Diogelwch, Adran Iechyd a Gwasanaethau Cymdeithasol Quality and Safety Improvement Branch, Department of Health and Social Services
Hugh Bennett	Dirprwy Brif Swyddog Deintyddol, Adran Iechyd a Gwasanaethau Cymdeithasol Deputy Chief Dental Officer, Department of Health and Social Services
Phil Chick	Adran Iechyd a Gwasanaethau Cymdeithasol Department for Health and Social Services
Peter Farley	Pennaeth Adran Dros Dro, Is-adran Diogelu Iechyd y Cyhoedd, Adran Iechyd a Gwasanaethau Cymdeithasol Acting Head of Division, Public Health Protection Division, Department of Health and Social Services
Gareth Griffiths	Adran Iechyd a Gwasanaethau Cymdeithasol Department for Health and Social Services
Siân-Marie James	Adran Iechyd a Gwasanaethau Cymdeithasol Department for Health and Social Services
Dr Tony Jewell	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Peter Jones	Cwnsler i Wasanaeth Seneddol y Cynulliad Counsel to the Assembly Parliamentary Service
Karen Morgan	Adran Iechyd a Gwasanaethau Cymdeithasol Department for Health and Social Services
Ann Lloyd	Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol Head, Department for Health and Social Services
Mike Shanahan	Adran Iechyd a Gwasanaethau Cymdeithasol Department for Health and Social Services
Sarah Watkins	Adran Iechyd a Gwasanaethau Cymdeithasol Department for Health and Social Services

Eraill yn bresennol
Others in attendance

Will Bee	Cyfarwyddwr, Comisiwn Hawliau Anabledd Cymru Director, Disability Rights Commission Wales
David Groves	Swyddog Polisi, Comisiwn Hawliau Anabledd yng Nghymru Policy Officer, Disability Rights Commission Wales
Laura Jerram	Pennaeth Polisi a Datblygu Dros Dro, Comisiwn Hawliau Anabledd yng Nghymru Acting Head of Policy and Development, Disability Rights Commission Wales
Hilary Neathey	Asiantaeth Safonau Bwyd Food Standards Agency
Joy Whinney	Cyfarwyddwr, Asiantaeth Safonau Bwyd Director, Food Standards Agency

Gwasanaeth y Pwyllgor
Committee Service

Jane Westlake	Clerc Clerk
Catherine Lewis	Dirprwy Glerc Deputy Clerk

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

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

[1] **Rhodri Glyn Thomas:** Bore da a chroeso i'r cyfarfod. A oes datganiadau o fuddiant? Gwelaf nad oes. Yr ydym wedi derbyn ymddiheuriad oddi wrth Karen Sinclair, sy'n methu â bod yma'r bore yma.

Rhodri Glyn Thomas: Good morning and welcome to the meeting. Does anyone have any declarations of interest? I see that there are none. We have received apologies from Karen Sinclair, who cannot join us this morning.

[2] Gwnaf y datganiadau arferol er mwyn y bobl sydd yn yr oriel. Credaf eu bod yn weddol gyfarwydd â'n trefniadau. Os bydd angen i ni adael yr ystafell, dylech ddilyn cyfarwyddiadau'r tywysyddion. Dylech sicrhau bod offer technegol wedi'u diffodd yn llwyr—nid yw'n ddigonol eu gosod i fod yn dawel.

I will make the usual announcements for people in the public gallery. I think that they are fairly familiar with our arrangements. If it becomes necessary to leave the room, you should follow the directions of the ushers. Please ensure that all electronic equipment has been fully switched off—they should not be left in silent mode.

9.31 a.m.

Adroddiad y Gweinidog
Minister's Report

[3] **Rhodri Glyn Thomas:** Dylwn nodi bod papur atodol ar brachytherapi. Credaf fod y Gweinidog am ddweud gair am hwnnw wrth gyflwyno ei adroddiad.

Rhodri Glyn Thomas: I should note that there is an additional paper on brachytherapy. I believe that the Minister wants to say a word about that as he presents his report.

[4] **The Minister for Health and Social Services (Brian Gibbons):** In the original statement we pointed out that, between now and the commencement of the scheme on 1 April, individuals could be treated on a case-by-case basis with Health Commission Wales. It would be useful to clarify that we have been able to secure the necessary funding for Health Commission Wales to look at the individual cases more generally than on the strict case-by-case basis which they were planning to follow up to now. So, people who are in the transition phase between now and 1 April should contact their consultant urologist, who can make the necessary arrangements through Health Commission Wales.

[5] **Rhodri Glyn Thomas:** Mae hynny i'w groesawu gan bawb, ac yr wyf yn falch o gydnabod hynny ar ran y pwyllgor.

Rhodri Glyn Thomas: That will be welcomed by everyone, and I am pleased to recognise that on behalf of the committee.

[6] Dechreuwn gydag eitemau 1 i 4 o adroddiad y Gweinidog.

We will start with items 1 to 4 of the Minister's report.

[7] **Jonathan Morgan:** As I am the only one here, Chair, apart from the Deputy Minister and the Minister, I will start. On point 2, physicians' assistants, I place on record my support for the scheme that the Government was looking at, because I think that this is a sensible idea. You could look at a range of schemes—as I know has been done in the USA—and see that this scheme works quite well. I am saddened to see that the project has been suspended. I know that we will soon enter the period of purdah and that we will go into recess in a month, but is this something that officials and the Government generally are quite keen to pursue? In the longer term, this is an objective that I would like to see achieved.

[8] **Brian Gibbons:** I was certainly disappointed to be informed that it was not possible, because there was a fairly good initial response from practices—around eight to 10 of them seemed to be quite keen—and it is not fully clear precisely why all of those practices eventually opted out. We need to monitor what is going on in Scotland and see what lessons can be learned from there as well as looking at what is going on in England. We can come back to it again. Having said that, the group that was involved in trying to move this forward also stated that there are existing healthcare professionals, particularly nurses, who could do a considerable amount of this work. So, I think that that is something that we can look at again. However, there are a number of practices, particularly salaried practices in the Valleys, where nurses are working as the first point of contact and seeing patients. Patients have the choice between going to see the nurse as the first point of contact. So, a little of that is already happening. We should continue to keep an eye on it and maybe come back to it if the circumstances are more favourable.

[9] **Jonathan Morgan:** I have a quick follow-up question. If, for some reason, it is decided that it is difficult to pursue the concept of a physician's assistant, bearing in mind that there is clearly a useful role there that can be fulfilled, would it not be better to try to ensure that we have a greater number of practice nurses working in GP surgeries, because, as you rightly said, they have a strong role to play? One way to fill in those gaps is to make better use of those practice nurses. Perhaps, over a longer period of time, it might be more sensible to try to recruit additional practice nurses at GP surgeries to help to fulfil these sorts of roles.

[10] **Brian Gibbons:** These would have to be nurse practitioners, or even consultant nurses, because their skill levels would be considerably higher than those of the typical practice nurse, but I take your point.

[11] **Rhodri Glyn Thomas:** Os nad oes mwy o gwestiynau ar bwyntiau 1 i 4, symudwn at bwyntiau 5 i 8.

Rhodri Glyn Thomas: If there are no more questions on points 1 to 4, we will move on to points 5 to 8.

[12] **Jonathan Morgan:** I have a question about point 3, on referral management centres. When were they introduced in England? I assume that they were introduced a few years ago.

[13] **Ann Lloyd:** They were introduced five years ago.

[14] **Jonathan Morgan:** Why has it taken so long for us to identify this as a major weakness within the NHS in Wales? You say that it is a weakness in terms of the NHS's ability to plan and develop services. Why have we waited five years, from when referral management centres were introduced in England, to do something similar in Wales? I would have thought that it was pretty clear from the outset that they were going to play a valuable role in terms of what they were set up to do in England and we could have established them a lot sooner. Why has there been this five-year delay between what has happened here and what has happened over the border?

[15] **Brian Gibbons:** There are referral management centres in Wales; I think that they are already around 15 to 18 months old. Certainly, 12 or 15 months ago, there were two or three, and now there are seven. So, they have not just started now; we are going back 12, 15 or 18 months. People think that they were universally introduced in England. However, the number of referral centres was also gradually built up in England, and, if we look at it in proportionate terms, we are doing relatively well. There is research that we can make available if people are interested in looking at it. There is not a single model in England, and if you look at the original research that was carried out here by the National Leadership and Innovation Agency for Healthcare, there are around nine different models and the referral centres are doing little bits of different types of activity. One reason why this research was carried out was to try to distil what was making sense and working well. It is not something that has started now; it has been there for 12, 15 or 18 months. The numbers are gradually building up. The fact that this report has been published gives us an evidence base. I met some of the researchers in the autumn, and, on that basis, I decided that we had enough information to push out a more consistent approach.

[16] **Rhodri Glyn Thomas:** Symudwn ymlaen at bwyntiau 5 i 8.

Rhodri Glyn Thomas: We will move on to points 5 to 8.

[17] **Helen Mary Jones:** I have a question about point 4 first, Chair, on social work qualifying training and the annual review of trends 2005-06. I would like to hear more from the Minister about the fact that paragraph 4.3 notes that he expects employers to take into account 'Fulfilled Lives, Supportive Communities' when engaging in workforce planning, which is evidently sensible. Can you say a bit more about what you would be expecting them to put into retention strategies, because I have an increasing concern that people are going into social work and not lasting very long? I would like to hear a bit more about that and what could be done on a national level to give a lead with those strategies.

[18] **Jenny Randerson:** On the same issue, I have previously voiced some concern about the current three-year degree approach, because people are qualifying to become social workers at a much younger age. I fear that that could lead to lower retention, because the shock factor of social work is considerable—I know, as my daughter is a social worker. Maturity and life experience have a significant part to play in being able to cope with the pressures of social work. Although I have not had an opportunity to look in detail at the announcement that you made this week, I read that you are going to rely much more on social services departments. That will have implications for the number in the workforce. Will that require an expansion of the workforce, and, if so, how will you achieve that? Finally, what progress has there been towards a unified pay and conditions structure?

9.40 a.m.

[19] **Brian Gibbons:** I will ask Ann to spell out the detail, but the general approach that has been adopted follows on from the Garthwaite report. One of the report's big conclusions was that it was a mug's game if every local authority or social services department tried to solve this issue on their own, and that there needed to be consistency across the patch. If that approach was not taken, there would be a merry go round of social workers joining particular departments—if there was a recruitment problem next door, other departments would just up their grades, or whatever, and social workers would move over. That would result in great instability, and so forth. So, local authorities as statutory bodies have started to work together. In fairness to the Welsh Local Government Association, it has been fairly supportive of this. In most parts of Wales, local government is taking a more spatial view of recruitment and retention, and trying to have some consistency along the lines that Jenny mentioned. I accept that there is not a dogmatic and rigid approach, and that there is a flat pay scale everywhere.

[20] Your daughter and young social workers, particularly if they work in the area of child protection or child care, are undoubtedly going into high pressure work. I was never clear about what the Garthwaite report had to say about a uniform approach. It seemed reluctant to go down the road of recognising a specific approach for people in child protection and children's services. I have said on many occasions that I found that to be a difficult conclusion for the reasons that you have mentioned, in that it is the most pressurised and difficult part of social services. It still seems to take the view that the best approach is a uniform approach across all services, but it has not convinced me that that is the best policy. However, the Garthwaite report was written by professionals in the field and ministerial dictat should not override the professional judgment of people at this level. The care council is involved in much of this work, and it has been more actively involved in standard setting for social workers, and the social care workforce in general, since the introduction of the degree course. It is becoming a much bigger player, working with local authorities and also independently with the social care workforce.

[21] This is the first time that the issue of the three-year degree course has come up in the way in which you have described it, and I do not know if Ann has a view on it. Some of what you say makes sense—it sounds credible—but I do not know whether the care council or anyone else has picked it up as an issue.

[22] **Ms Lloyd:** Yes, it has, and the consequences of a three-year degree and the structure of the workforce that you are able to put out in the field is being actively debated along the lines of calculating the risk that is associated with individuals' work and the competencies that are therefore required to enable them to undertake the role, and with that goes the experience that they have. You are right about retention, because people are getting burned out far too early—there is no point in training more social workers if the retention policies are insufficient. As part of the implementation of 'Fulfilled Lives, Supportive Communities', a major stream of work will be done on the workforce with the care council. Hugh Gardner will lead that work with Tony Garthwaite—we hope that he will be involved and continue with the work that he has done for us. They must get a balance and use best practice to raise the status of social work, so that more people are happy and willing to be trained in that work and stay in it.

[23] It is no good continuing to train people without giving them the support structures within which they can operate effectively for families. As you may know, we have also established the improvement agency this year, funded with the WLGA, and one of the main streams of work that we are discussing with it is the issue of workforce retention. People, as the Minister says, feed off each other, and start to pay more to attract staff, but that is a short-term solution, and as part of becoming a profession there has to be an element of equality in determining why you should be paid what you are paid. We are working with local government on their regional commissioning styles to try to sort that out, because otherwise it

is just not going to work.

[24] **Helen Mary Jones:** In point 5, the joint review evaluation report sounds positive, and one's experience on the ground also suggests that the reviews are delivering—it has been a good process, and one that is getting better. However, I am concerned about the amount of work that it takes, as you highlight in point 5.3. You say there that:

[25] 'Actions are being taken to help further reduce the demands on Councils and reviewers'.

[26] I wonder if you can say a bit more about what actions those are. I realise that it is a difficult balance, because there will always be a burden of work in gathering that information, and that is quite proper—the information needs to be gathered—but anything that could be done to streamline the process and enable the reviewers to do more reviews must be for the better. So I am just interested to hear what sort of actions might be taken, without, of course, wanting to reduce the thoroughness of the process in any way.

[27] **Brian Gibbons:** We have a bit coming up later on performance management in social services, and one of the reasons why I included that is because there are a fair number of issues on social services in this report, and there is a link to performance management here. As local authorities become more proficient in performance management, and as ICT becomes more embedded in local authorities and social services departments, then the accumulation of evidence becomes that little bit easier. Part of the problem here is that this is literally a paper chase, in trying to get the paper together and physically going through it. Even though, in fairness to the joint review team, it tries to give an indication to the local authorities of what they require, it is a bit like me coming before this committee; items on the agenda have a heading, but then you try to cover every other possible permutation of that issue—

[28] **Jenny Randerson:** Never—you have seen through it. [*Laughter.*]

[29] **Brian Gibbons:** That is true. However, many local authorities create a vast amount of paperwork for themselves. The inspectorate might ask to look at one particular area of work, but the local authority tries to anticipate where that will lead, creating a vast amount of extra work. The joint review teams regularly tell them, 'Look, when we say that we want to see A, we mean that we want to see A, not A1, A2, A3, and so on'. As people become more familiar with the process, when the joint review team says that they want to see A—

[30] **Helen Mary Jones:** They will give them A.

[31] **Brian Gibbons:** Yes, because they have confidence in the process. However, ultimately, the way forward on this is to use the investment that is going into ICT, and to use local authorities' own performance management mechanisms, so that 80 or 90 per cent of the data will be directly available to the joint review team—it will be the routine management data that local authorities have themselves. I suppose that the ideal would be, over time, for the joint review to be picking up underperformance, and then beginning to validate the performance management—ensuring that the information that they are presented with reflects what is happening on the ground. However, we are a few years away from that. A similar approach is being taken by Healthcare Inspectorate Wales with regard to the healthcare standards once it starts evaluating the health service against those standards. That is the direction of travel. We are halfway between the requirements that local authorities felt they needed to meet in the initial round of evaluations and a situation in which meeting the demands should be fairly routine because of ICT and new performance management. So I think that we are halfway along that spectrum.

9.50 a.m.

[32] **Rhodri Glyn Thomas:** A oes cwestiynau eraill ar bwyntiau 5 i 8? Gwelaf nad oes, felly symudwn at bwyntiau 9 i 12.

Rhodri Glyn Thomas: Are there more questions on points 5 to 8? I see that there are none, so we will move to points 9 to 12.

[33] **Jenny Randerson:** On point 9, on the doctors' negotiations, I would like some information from the Minister on how much active input there has been into these from a Welsh point of view and whether there are any plans to diverge from any kind of basic UK-wide contract? I would like an assurance that it has been better thought-through than the GP contracts were.

[34] **Jonathan Morgan:** The Minister has now confirmed support for the proposed agreement, so could you detail what is in the agreement and could you confirm what additional resources, if any, are being allocated? In three years, you have spent £40 million more on the GMS contract than you originally thought that you would spend, so are there any budgetary consequences, and, if so, what are they?

[35] **Brian Gibbons:** There is a budgetary consequence and a line in the approved budget, so that should be there. I cannot remember what the figure is, but I think that the implementation cost is of the order of £6 million or £7 million. The contract, like all of these contracts, except for the consultant contract in Wales, largely with the profession's agreement and at its desire, is negotiated at the UK-wide level. We have brought in one or two small areas of variation in Wales, particularly in relation to work planning, because we have taken a different approach to that. If you remember the final stages of the implementation of the consultant contract in Wales, there was much discussion around work planning and so on. That, in fairness, has served us very well in practice and we are taking the same approach to the speciality doctors in relation to work planning, which will be slightly different in Wales. There are one or two other little issues in relation to private practice that I am not 100 per cent sure about. I would say that it was 98.5 per cent the same contract, but I think that the big difference is the work planning element.

[36] **Jenny Randerson:** How much input did you have, and what was your role?

[37] **Brian Gibbons:** Our officials are kept informed and a dialogue goes on between the main negotiators and our officials, but the Assembly Government, or even our officials here, would not be part of the negotiating team per se. We would be kept informed and our officials would go to London and discuss with people and we would say whether or not we thought that this was the right direction in which to go and so on, but it is predominantly a London-based process.

[38] **Ms Lloyd:** We take a view once the ballot has been concluded, as we did with the consultant contract.

[39] **Helen Mary Jones:** On point 10, on the performance management development fund, I wish to raise a related issue raised with me on the integration of the children's system into the new computerised system. I had a meeting with some senior children social work managers in one county in my region—it would not be appropriate to say which at this stage—who were very concerned about this system. What they said to me was that they and the social workers that they manage feel that unless something is done to make the system more flexible—these are their words, Minister, not mine; I am not operating the system—they are going to get to the point where their practice is driven by the need to fill in the computerised form, rather than the computerised form recording their practice. This is one of our better-performing county councils, this is not—well, we will not embarrass Powys by mentioning it by name. This is a county council that has a good reputation for the standard of

its social work with children at present.

[40] These managers have been very engaged in the process of working with and developing this system, and they tell me that they are reporting problems in using the system consistently and that it is almost like the sketch from *Little Britain*, in that the response that they get is that the computer says 'no', that they cannot do what they want, and that the system cannot be made flexible. They fill in a form for a child protection case involving a newborn baby and have to tick a box about whether it has problematic alcohol misuse and whether it is a parent. That cannot be right. I am a former social worker, and having been shown this system I can see that you would spend hours on this, even once you were au fait with how the system operated. This is a real plea to look at this to see whether we can make the system more flexible.

[41] They are not saying that they do not want to have computerised records—there are all of the points that you were making earlier about that making it easier to monitor and to share information. However, one of them told me that it is getting to the point where the system is putting so much pressure on them to share information that it is getting in the way of them acquiring that information from children and families in the first place. I am really worried about that—it feels like a law of unintended consequences and like something that we are trying to get right, but which could go profoundly wrong. It is bad enough for front-line social workers to be talking about industrial action, refusing to do it, working to rule and all of that, and this, as I said, in a department—and perhaps I will tell you privately which one it is, Minister—where people are really good at what they do and are effective at protecting children.

[42] So, this is a real plea to have another look at the integrated children's system to see whether it can be made much easier, so that it is a system that responds to good practice, rather than people who are currently engaging in good practice telling me that they are fearful that they are being landed with a system that will drive them away from the effective work that they currently do with children and families. As I said, I am only reporting what I was told; it looked pretty dreadful to me, but almost anything that is computerised looks dreadful to me, so I am not the right person to ask. However, I was really worried and so were they and I thought that it was best to address here, rather than through formal questions, because this is not about point scoring. They are really worried abut this and they want to get it right, and I think that we would all share an aspiration to have information easily exchanged between agencies, but not at the price of it getting in the way of good childcare practice.

[43] **Brian Gibbons:** Neath Port Talbot is on its own, it is not in a consortium, but the other local authorities are in four consortia. I do not know the specifics, but it may be that the problem that you are highlighting is related to one consortium, and, if so, then there would be two or three other local authorities with the same problem. It may be an even wider, generic problem, right across all of the consortia. It would be best for me to take that concern away and pass it on to the people who are working on informing social care. Between now and the start of the implementation of 'Fulfilled Lives, Supportive Communities' next year, as you may remember, there is a long checklist of eight to 12 things that we need to do, so that when implementation starts in 2008, it will be fit for purpose from day one. One area that we wanted to look at in particular was the unified assessment process for adults, because a lot of the problems that you are describing translate across to the unified assessment process.

10.00 a.m.

[44] Even on that, it was acknowledged that we needed to look at the integrated children's system as well—that, in some ways, you are feeding the monster, rather than the monster helping you to get on with the job. Therefore, we will take that away, although I do not suppose that we will have time to come back to you before the end of the second Assembly.

[45] **Helen Mary Jones:** Perhaps you could write to me, Minister, and I could pass that on. I am grateful for that. I wish to stress that these are not people who do not want to make the system work. I can think of some people, from my days as a social worker, who could be barely prevailed upon to keep paper records, never mind filling in the forms. However, people are not coming from that, 'We do not want to do it' angle; it is just, 'We do not want this to be everything that we do'.

[46] **Brian Gibbons:** I believe that it is also fair to say that, in relation to SSIW, to use the terrible phrase, this is an iterative process. I do not believe that we are at the stage at which we say that there is a finished model of the integrated children's system; people are trying to work their way through. There are problems in that there is only a limited amount of consultant expertise out there—only a limited number of companies have the necessary capacity to be able to work with the organisations to allow this to move forward. The speed of progress is probably slower than we expected, because there are bottlenecks in terms of capacity, and so on. Therefore, what you say may, in some ways, reflect some of the practical difficulties that seem to be emerging on the ground.

[47] **Helen Mary Jones:** I believe that it reflects some of those practical difficulties, but it also reflects a sense that front-line practitioners, in this particular case, feel that they are not being listened to in the process. Obviously, they would not bother to come to see a politician about it if they felt that their concerns were being fed up effectively through the stream. Therefore, it reflects practical difficulties, but it also reflects a sense that there may be cultural problems in responding. However, thank you for that, Minister.

[48] **Brian Gibbons:** It will be in more than one—that is for sure.

[49] **Helen Mary Jones:** Thank you. I appreciate your positive response, Minister. I will be speaking to people later today and I can feed that back, and I believe that they will be very relieved.

[50] **Rhodri Glyn Thomas:** Os ydych yn gohebu â Helen Mary Jones, Weinidog, buasai'n ddefnyddiol pe baech yn anfon copi at weddill aelodau'r pwyllgor, oherwydd yr wyf yn siŵr y bydd ganddynt ddiddordeb yn hynny.

Rhodri Glyn Thomas: If you do correspond with Helen Mary Jones, Minister, it would be useful if you could send a copy to the other committee members, as I am sure that they will be interested in that.

[51] A oes cwestiwn ar bwynt 11? Gwelaf nad oes. A oes cwestiwn ar bwynt 12? Os nad oes gan Aelodau eraill gwestiwn, mae gennyf fi gwestiwn ar y pwynt hwnnw. Fel y gwyddoch, Weinidog, yr wyf wedi codi'r mater hwn gyda chi, yn arbennig ynghylch y cyffuriau newydd sydd ar gael. Yr ydych wedi datgan bod pob rhwyddineb i'r byrddau iechyd lleol gynnig y cyffuriau hyn i gleifion sydd eu hangen. Fodd bynnag, y broblem yw nad oes cyllid ychwanegol ar gael i'r byrddau iechyd lleol wneud hyn. A ydych yn rhagweld problem yn y fan hon? Yr wyf yn gofidio ein bod yn mynd yn ôl at sefyllfa o ddarparu ar sail cod post. Dyna'r sefyllfa y buom ynddi gyda Herceptin. Yr ydym yn ôl yn y sefyllfa honno, gyda rhai byrddau

Are there any questions on point 11? I see that there are not. Are there any questions on point 12? If no other Members have a question, I have one on that point. As you know, Minister, I have raised this matter with you, specifically regarding the new drugs that are available. You have stated that local health boards can offer these drugs to patients who need them. However, the problem is that no additional funding is available for the local health boards to do this. Do you anticipate a problem here? I am concerned that we are going back to a situation where provision is a postcode lottery. That was the situation we were in with Herceptin. We are back in that situation, where some local health boards will allow these drugs to be

iechyd lleol yn caniatáu i'r cyffuriau hyn fod ar gael, tra bod eraill yn dweud nad oes ganddynt gyllid i wneud hynny. A allwch gynnig esboniad ar hynny?

provided, but others will say that they do not have funding available to do that. Can you offer an explanation?

[52] Did you wish to come in on point 12, Lynne?

[53] **Lynne Neagle:** May I listen to Brian's reply first?

[54] **Rhodri Glyn Thomas:** Yes.

[55] **Brian Gibbons:** This relates to two or three new drugs that are coming in for macular degeneration. I do not know whether it is two or three that have passed for licensing—one of them certainly has. One is close to being licensed, and I believe that another one, which used to be used for bowel cancer, is now being proposed for use as part of this line of treatment. Strangely enough, in relation to this condition and some of the drugs being used in its treatment, the underlying logic was thought to be a mechanism to treat bowel cancer in particular. Therefore, the process is being transferred to this problem.

[56] There is a grey area between the time when the drug is licensed and when it is evaluated by the National Institute for Health and Clinical Excellence. The NICE evaluation aims to get rid of the postcode lottery, and, once it makes its evaluation, by and large, we expect the health service to live with that decision, whether it is for or against. If the decision is in favour of a drug, organisations have a statutory duty to comply with that, generally within three months. That is the mechanism to get the postcode lottery out of the system. Until NICE does its evaluations, there is that interregnum during which, if you want to use the term 'postcode lottery', that is the situation, but the whole point of the NICE evaluations is, where possible, to get rid of that postcode lottery. Therefore, the Assembly Government has given the extra resources to the All Wales Medicines Strategy Group so that it can do these extra evaluations on new drugs to try to narrow that period between the licensing of a drug and its being properly evaluated by NICE, and, once it has the NICE evaluation, that will get rid of the postcode lottery.

[57] I suspect that there may still be some gaps in the system, but unless you take the view that, once a drug is licensed and no further evaluation is required, and that there is no process such as the NICE evaluation, it is difficult to see how you can totally eliminate what hopefully in most instances will be just a relatively short time in which the variation exists.

[58] **Rhodri Glyn Thomas:** Yn y cyd-destun hwn, y broblem gyda'r cyflwr arbennig hwn yw bod rhaid wrth y feddyginiaeth yn fuan, weithiau o fewn dyddiau, neu gall rhywun fel arall gael ei hun yn ddall. Yr hyn sydd wedi bod yn digwydd yw bod pobl nad ydynt wedi gallu cael y cyffur oddi wrth y bwrdd iechyd lleol, wrth i'r bwrdd dalu amdano, a hynny hyd at £10,000, yn ôl yr hyn a ddeallaf. Dim ond pobl mewn rhai ardaloedd sy'n cael y cyffur hwn, tra bod pobl eraill yn dioddef a'u cyflwr yn gwaethygu, ac nid oes modd adfer eu golwg hwy unwaith y mae hynny wedi digwydd. Deallaf y problemau o'ch blaen, ond mae elfennau arbennig yn perthyn i'r achos hwn.

Rhodri Glyn Thomas: In this context, the problem with this particular condition is that the medication needs to be administered directly, sometimes within days, otherwise someone could find him or herself blind. What has been happening is that people have not been able to get the drug from their local health boards, with the boards funding it up to a value of £10,000, as I understand it. Only some people in certain areas have access to that drug, while others have to suffer while their condition deteriorates, and once that has happened, their sight cannot be restored. I understand the problems that you face, but this issue is an exceptional one.

[59] **Lynne Neagle:** I agree with your remarks, Chair, in that I have being trying to establish whether Torfaen LHB will fund Macugen for a constituent of mine. As I understand it, NICE is not going to evaluate this drug until next year—[*Interruption.*] I have just heard that it will be done by August 2007, but still, there is a delay. I spoke to the RNIB about this matter, and it said that blindness can occur within as little as three months. Obviously, this is causing considerable anxiety not just for my constituent but for all people affected. Consultants are telling people that they should have this drug, and they are even talking to patients about the possible costs of their paying for it. If anything can be done to accelerate this process, possibly via the all-Wales medicines group, then it needs to happen.

[60] Another thing that would be helpful, which Torfaen LHB has told me it is looking at, would be more information about the different policies of LHBs on this issue. I have had very contradictory replies. For example, Torfaen LHB is reasonably positive, while the Gwent NHS Trust was not at all helpful in its response. It would therefore be good to have more detail on exactly what the policies are across Wales.

[61] **Brian Gibbons:** This is a difficult area, and until NICE or the All Wales Medicines Strategy Group decides, individual health organisations have to make a choice, once the drug has been licensed, as to whether they are sufficiently happy that it is safe enough for general use, and whether it can deliver the treatment promises that the licensing indications show. Of course, they will also have to evaluate, particularly if it is a very expensive drug and if they are unclear about the clinical benefits and risk profiles, what supporting that drug will mean in relation to other priorities faced by the local health board. It is a difficult decision that local health boards will have to make.

10.10 a.m.

[62] Clearly, different decisions will be made by individual local health boards. For example, they will take different views on the risk profile of the drug, on the possible therapeutic benefit of the drug and on the possible other pressures on their budgets if they decide to go down that route. Once NICE or the All Wales Medicines Strategy Group comes to a decision, that variation will be taken out of the system, so that there is consistency in the system and a general approach that everyone has to sign up to. So, there will be no discretion in the matter.

[63] I think that the only other way that we can get rid of this particular issue is to say that no drug should be licensed until the full evaluation takes place. However, that is very tricky because a lot of drugs come to the market and the number of people who have been evaluated on the drug are relatively small, but those numbers, even though they are relatively small, are sufficient to allow the licensing to take place. I may be wrong, but I suspect that the pharmaceutical companies in particular would be very unwilling—I do not know whether Tony takes a view on this—if we said that no drug should be licensed and put on the market until it had been subject to a NICE-type or an All Wales Medicines Strategy Group evaluation. If we took the approach that there needed to be a full independent evaluation of all drugs in order to meet the NICE standards before they are licensed, we would not have this sort of difficult intermediate period. However, unless we can deliver that, there will always be a short period in which uncertainty exists. I do not know whether Tony wants to come in on that.

[64] **Rhodri Glyn Thomas:** Iawn. Tony sydd i ymateb yn gyntaf, ac wedyn caiff Jonathan a Lynne ddod yn ôl.

Rhodri Glyn Thomas: Fine, Tony can comment first, and then Jonathan and Lynne can come back in.

[65] **Dr Jewell:** This is a difficult issue. You have to remember that these patients will

tend to be under specialist services and they will have had assessments. There is wet and dry macular degeneration, but we are talking about wet. For wet macular degeneration, there is a treatment that NICE evaluated in 2003, namely the photodynamic treatment, which is okay for 36 per cent of people with wet macular degeneration. These new drugs look very promising, in the same way that the early evidence for Herceptin did and when everyone said that it looked promising. However, the formal evaluation has not been done and NICE will report in August, so we have a six-month period, and that is what we are all worrying about. However, the licensing process for drug companies is for the drug to go on the market—and there are different tests—as opposed to a healthcare system saying that it wants to use a drug. They are different.

[66] I do not think that Wales will be able to do what the Minister said in terms of international agreements on licensing, because we would not be able to say that this drug could not be licensed for sale on the market in Wales. What we can say is whether NHS Wales will fund the treatment for this application. I do not think that the all-Wales medicines strategy could do it before August, if it is to do it properly, and that is the difficulty at the moment. So, we are in this difficult situation where clinicians, with the commissioners, will have to make exceptional case decisions until August, when we have the NICE results. NICE could say that it does not work for all these patients, or that it only works for the same proportion for which the photodynamic treatment works. We simply do not know the outcome at the moment.

[67] We all recognise the difficulty that clinicians, patients and their families find themselves in during this period, and recognise that we do not have a fast enough appraisal system at the moment. We are all lobbying NICE, and we set up the All Wales Medicines Strategy Group because we all recognise that if we could collapse the timescale between licensing and appraisal for the NHS, it would be better for us all. On the other hand, you have to do it in a quality way.

[68] **Rhodri Glyn Thomas:** Credaf mai'r hyn yr ydym yn ei ofyn yw eich bod chi, fel Gweinidog, yn annog byrddau iechyd lleol i gynnig y cyffuriau hyn, gymaint â phosibl, ond derbyniaf mai penderfyniad cyllido iddynt hwy ydyw yn y pen draw. Pan fo'r cyffuriau ar gael, yr ydych wedi datgan bod gan y byrddau iechyd lleol rwydd hynt i'w cynnig i gleifion. Mae angen osgoi sefyllfa lle mae un bwrdd iechyd lleol yn gwneud hynny ac un arall, efallai drws nesaf, yn penderfynu peidio â gwneud. Gadawaf i Jonathan a Lynne ddod i mewn ac yna cewch ymateb, Weinidog.

Rhodri Glyn Thomas: I believe that what we are searching for is that you, as Minister, encourage the local health boards to make these drugs available, as much as is possible, although I accept that it is a funding decision for them at the end of the day. Where the drugs are available, you have stated that the local health boards are free to offer them to patients. We need to avoid a situation in which one local health board is doing that and another, perhaps next door, decides not to do so. I will allow Jonathan and Lynne to come in and then you may respond, Minister.

[69] **Jonathan Morgan:** The point that I want to raise is that raised by the chief medical officer, namely whether a licence should be delayed until the evaluation has taken place and until there is agreement with regard to the process, which would be difficult for us to breach. I think that the main issue is the point at which you allow a drug to be used within the NHS, and how quickly. What does the licence achieve? Is it merely one staging post, or is it a fairly thorough examination? If it is a fairly thorough examination of the effectiveness of a drug and, therefore, states that a drug is safe to be used, should a clinician be able to prescribe that drug before it reaches the end of the full evaluation process?

[70] If you are going to speed up the role of the All Wales Medicines Strategy Group, it would be a good idea for us as an Assembly to examine what the AWMSG does. To use a

religious analogy, it reminds me of the College of Cardinals appointing a new pope; you know the outcome, but the process is a real mystery. This is an advisory group, as I see it, but I do not know how it is constituted, who appoints its members, for how long it sits as a group, or what its workload is. We really do not get much information about what this organisation does. If you are going to expand its role, as you have noted in point 13 of the report, and look at improving the speed of the process of the work that it does, I think that we ought to spend more time examining its role and asking some questions, because it will certainly become more influential. The issue for me is how quickly that appraisal process will take place. Once a drug has been licensed, that is the principal most important staging post in the process of the National Institute for Health and Clinical Excellence. The question that most people ask is, if it has been licensed, why can it not be used?

[71] **Rhodri Glyn Thomas:** Mae pawb am ddod i mewn ar y pwynt arbennig hwn. Caiff Lynne ddod i mewn yn gyntaf, wedyn Jenny, ac wedyn Helen Mary. Yna, caiff y Gweinidog ymateb.

Rhodri Glyn Thomas: Everyone wants to come in on this particular point. Lynne may come in first, then Jenny, and then Helen Mary. The Minister may then respond.

[72] **Lynne Neagle:** I just want to make an observation about cost. I understand completely that these are expensive drugs, and that we are talking about different budgets when we talk about the cost of blindness. However, we have to remember that the cost of someone suddenly going blind is significant indeed, in terms of social care and adaptations, and so on. Potentially, you are also talking about sons and daughters giving up work to look after their elderly parents. So, we have to see it in that context. If these drugs work, they can have a profound impact in terms of saving money.

[73] **Jenny Randerson:** Lynne has said exactly what I was going to start by saying. From the point of view of the patient—and, actually, anyone with any common sense—the fact that an LHB says that it cannot afford a certain drug, and so someone who would not otherwise have gone blind does so as a result, means that there will be a considerable impact on social services, which will have to provide care for that blind person from then onwards. The cost of that care would be heaps more than the cost of the drug. The public cannot get their heads around the logic behind that kind of separation of the budgets. Common sense dictates that this is a daft approach to take. I would say that the same thing applies to the drugs for Alzheimer's disease. NICE decided that it was not going to fund those drugs, and yet we have shoals of people coming forward to us to say, 'Look what it did for me'.

[74] I endorse what Jonathan said about needing to know more about the role of the all-Wales group, because I have looked into it in considerable detail, via a number of questions to the Members' research service and so on when we tabled that motion for Plenary. So, I did a lot of research on it and the more you know, the more complex it gets.

10.20 a.m.

[75] Finally, although I understand LHB autonomy and the principle of LHBs providing the care that is needed for the area, the idea that one LHB can decide that it is all right to prescribe a drug because it is important to stop a person going blind while another decides that it cannot afford it is unacceptable. That is not to do with local health care needs at all; it is just a budget-driven decision. I realise that these are immensely complex issues.

[76] **Helen Mary Jones:** I have never understood why it takes so long. Why do the NICE and the All Wales Medicines Strategy Group processes take so long after licensing? Is it a capacity issue? Is it that there are so many new medicines coming onto the market that it is very difficult to process them all, and that they then have to be prioritised? With regard to the judgment that either the all-Wales group or NICE makes, I am also not clear about the

balance between effectiveness and cost-effectiveness. Whether the drug works and treats a condition effectively is one question—and there is another consideration, which, in an ideal world, would be the only consideration but it never is in the real world—and then there is the balance of whether it works well enough for enough people to represent good value for money. I find that balance difficult to understand, and I am not clear what weighting is given in the process to those two clearly different criteria for making decisions. I do not think that the public understand that either.

[77] To return to Lynne Neagle's point, for patients who believes that their sight could be preserved or, in the case of Alzheimer's drugs, that their quality of life could be improved, particularly if their doctors are telling them that, it is very difficult for them to understand why there is a separate process that queries whether it is okay for them to have that drug. Like Jenny Randerson, I realise that it is very complicated, and perhaps we cannot explore it fully today, Chair. However, we may want to include this in our legacy report for any future health committee. If we, as politicians with a special interest in health and social care, do not understand how this works—and I do not think that I do, really—we certainly cannot expect the general public in Wales to understand, particularly when we have the licensing process, then the All Wales Medicines Strategy Group doing one thing, NICE doing another, and further talk about how we might work with the Scottish approval process. I certainly do not think that I understand how all of that fits together, and so, in a sense, we cannot expect even clinicians to understand or accept a process that looks so complex to us. That is one way in which we may be able to progress this issue. Perhaps the Minister can answer questions on this particular medicine today, but we must look at this subject generally in more depth—that would certainly be done if I were back here.

[78] **Rhodri Glyn Thomas:** Yn sicr. Mae'n fater hynod o gymhleth, sydd wedi dod at sylw y pwyllgor fwy nag unwaith. Byddai'n addas inni gynnwys hwn yn y llythyr trosglwyddo i'r trydydd Cynulliad, ac i unrhyw bwyllgor sy'n dod ar ôl y pwyllgor hwn.

Rhodri Glyn Thomas: Certainly. It is an extremely complex matter, which has come to the committee's attention more than once. It would be appropriate for us to include this in the legacy letter to the third Assembly and to any committee replacing this committee.

[79] Weinidog, mae un neu ddau o faterion wedi'u codi yn awr ichi ymateb iddynt.

Minister, a number of matters have been raised for your response.

[80] **Brian Gibbons:** People's expectations of the licensing process for a drug—and I fear that stones will rain down on my head for saying this—are overly optimistic. When drugs are licensed, even fairly potent ones, the number of patients who benefit from it could be as small as a few thousand. Fairly catastrophic adverse effects can occur at an incidence rate of one in 1,000, and so, if a drug were then widely distributed in the population, the catastrophic implications of a not very common but not very rare side-effect could be quite serious. I was reading the *BMJ* recently, and one thing that came up in a number of articles, which really worried me—and I thought that we had got past this phase—was the tremendous commercial pressure on pharmaceutical companies to bring products to market and to cross that licensing threshold. We know of the problems with Viox, which have been well documented. I cannot comment a great deal on that, but people have said that thousands of patients have suffered strokes and heart attacks and have died because Viox came onto the market prematurely. If you are to believe some of the articles in the *BMJ*, had the process of evaluation run on for another six or nine months, Viox would probably never have got onto the market. However, because it got onto the market at that particular stage, thousands, if not tens of thousands, of people have potentially been adversely affected by it.

[81] There is also the controversy surrounding Seroxat—and I think that there was a

Panorama programme about it, although I have not seen it. What was the evidence base that brought that product onto the market so that that drug is now being used? The first issue that we need to consider is the massive commercial pressures on organisations to get the licence and to deliver that drug to the market. The fact that that drug has been licensed means that it has crossed certain minimum thresholds of quality and so on, but we must be happy that those quality standards are being met, and that is how some of the controversy regarding Viox has come about. Although such drugs have been licensed, major questions still remain, as Helen Mary said. The issue is whether or not we have the level of certainty that is required until evaluations are carried out by the All Wales Medicines Strategy Group, the National Institute for Health and Clinical Excellence or whomever. Until those more thorough evaluations are undertaken, can we be certain that the therapeutic benefits of these drugs are what they are claimed to be, that the side-effect profile is as benign as we are led to believe it is, and that a proper evaluation has been undertaken of the clinical risks versus the therapeutic benefits of the drugs? Very little of this goes on in approving the drugs to go to market; these are not issues that the licensing exercise takes into account. So, this is where evaluations by organisations such as NICE kick in and give us these pictures.

[82] I think that Tony is right that it looks like this drug for the eyes will be a big breakthrough, without a doubt. However, that drug is injected into the eye and it has the potential to damage other parts of the eye. The view at the moment is that, while other parts of the eye are potentially at risk from this drug being injected, for the reason that Lynne mentioned, it is worth taking that risk because of the catastrophic consequences of macular degeneration for the patient. However, there is a risk, and so there is a balance to be found in this. The licensing of the drug will not give us that; it is the subsequent evaluation through clinical trials and so on that will help to provide an answer on this. Yes, LHBs will obviously make decisions on the basis of funding, particularly if the drugs are expensive, but I am sure that LHBs' medical officers are not solely driven by costs; they are going to say, 'Hold on, we have been here before; we have seen wonder drugs appearing on the market and disappearing in two or three years'. Taking Practolol and Thalidomide had catastrophic consequences for people, which became obvious only after they had done so for two, three, four or five years.

10.30 a.m.

[83] In current medical literature, there is raging controversy over the process by which drugs come to the market and the level of evidence that should be available to allow that. So, I am always a little nervous when we have these debates, because there is such strong commercial pressure to get the drug widely accepted in the market, but we need to know that the drug delivers the promise on which it has been marketed. The same issue can be seen with Herceptin, although this might be a bit easier as this drug seems to be much more promising. Like Herceptin, the case seemed easier to make in lay person's terms, but this is a fiendishly complicated situation. Simple solutions will not serve us well in the medium term.

[84] **Rhodri Glyn Thomas:** Yr ydym i gyd yn derbyn ei bod yn sefyllfa hynod o gymhleth, Weinidog, ac yr ydym wedi cael trafodaeth gweddol eang ar y pwynt hwnnw—credaf ein bod wedi trafod pwynt 13 ar yr un pryd. Mae'n rhaid inni symud ymlaen, gan fod amser yn gwasgu, i'r tri phwynt olaf, sef pwyntiau 14, 15 a 16. Byddaf yn cymryd cwestiynau ar bob un o'r pwyntiau hyn, a gallwch ymateb iddynt wedyn, Weinidog.

Rhodri Glyn Thomas: We all accept that it is an extremely complicated situation, Minister, and we have had quite a broad discussion on this point—I think that we have discussed point 13 at the same time. We must move on, as time is pressing, to the final three points, namely points 14, 15 and 16. I will take questions on all of these points, and you can then respond to them, Minister.

[85] **Helen Mary Jones:** On point 14, I welcome the fact that this consultation will go out

shortly. I want to emphasise the issue about independence and refer the Minister back to the Waterhouse report and the things that the children's commissioner said about what needs to be done to sustain that independence. We had a long discussion with Voices from Care last night in the cross-party group on looked-after children with the Minister with responsibility for children, particularly from the perspective of looked-after children. There was agreement that there must be a national unit of some kind, but there was no agreement about what exactly it should do. However, I wanted to put on record the group's concerns that anything that is seen to be funded or managed by the local authority—or even one step removed, through a regional consortium—against which a young person or child in the looked-after system needs advocacy in order to make a complaint or to raise an issue will not be perceived by all looked-after children as being fully independent. I do not want a long response from the Minister today, but I want to put that on record following last night's discussion. I look forward to making those points as the consultation process goes through.

[86] I also have some points on the other issues.

[87] **Rhodri Glyn Thomas:** Cymerwn y pwyntiau i gyd yn awr.

Rhodri Glyn Thomas: We will take all the points now.

[88] **Helen Mary Jones:** In terms of healthcare standards—I have been looking for an opportunity to raise this slightly mischievous point—and standards and assessment criteria, I imagine that one of the things that needs to be looked at is an adequate numbers of beds. I want to raise with the Minister the issue about the proposals to cut the number of beds in Bronglais Hospital and across Ceredigion, which is of grave concern. I have no doubt that the Minister will say that it is an operational matter for the trust concerned, but, as I understand it, it is currently just a proposal by consultants. The Minister will be aware that it has given rise to some grave concerns; people are contacting me in my capacity as shadow health Minister and as one of their regional Assembly Members to say that it seems to be doing what was proposed under 'Designed to Deliver', but by the backdoor. So, I invite the Minister to reassure those people that that is not what is happening, if he is able to do so.

[89] **Jenny Randerson:** On point 16, non-emergency patient transport, I read the circular and I was pleased to see that ongoing cancer treatment—I think that that was the phrase used—was included. I want clarification, in the case of brachytherapy, that people travelling from north to south Wales to Velindre Hospital for their first course of treatment, as they will have to under your plan, will be eligible for that patient transport. I will also use this opportunity to say to the Minister that this has been a terrible muddle. We have pushed and pushed on this, and it has been like a dyke gradually giving way against the flood. As a result there is still confusion, and I invite the Minister to clearly state, first of all, whether people will be funded, as we were led to believe this week, for treatment in England between now and the end of the financial year; and secondly, will they be funded in England between now and the start of the Velindre service; and thirdly—

[90] **Rhodri Glyn Thomas:** Just on that point, Jenny, the Minister clarified that at the start of the committee meeting.

[91] **Jenny Randerson:** Sorry; I missed the first few seconds, did I not?

[92] Thirdly, then, I still want to place on record my concerns that people from north Wales will have to come to south Wales, to Velindre, because—

[93] **Brian Gibbons:** I will deal with that—sorry, I should not interrupt.

[94] **Jenny Randerson:** You said it all at the beginning, did you?

[95] **Rhodri Glyn Thomas:** No, that point was not covered at the beginning.

[96] **Jenny Randerson:** When I pressed you in Plenary, you said—although I can never remember whether it was you that I was talking to at the time, or the First Minister, though I realised the difference at the time of course, but looking back I cannot remember who I put the question to, though I think that it was on your statement. You say that people will have to come to south Wales for their treatment after the Velindre process is set up; that means an awful lot of travelling, and I think that it would be much better to send them to England. It would be much cheaper from the point of view of the health service, and more convenient for the patient, which is most important of all. However, my concern is that this travel scheme means that not every brachytherapy patient will be eligible for this transport.

[97] **Brian Gibbons:** To deal with Jenny's point, I can understand why it seems that a dyke has gradually been crumbling under public pressure, but the situation has always been that, once Health Commission Wales had done its evaluation, we were committed to providing a brachytherapy service. In this particular year there was a problem, simply because the tariff costs increased, mainly driven by payment by results, so that the budget that Health Commission Wales had for this particular service was suddenly used up on a much smaller number of patients. However, I have said on many occasions in this committee and in Plenary that the decision in principle to provide brachytherapy had been made, and we were just working out how that service would be provided, hopefully here in Wales. That has always been the position, and, in fairness, we have been able to negotiate that and we are in the process of setting that service up in Cardiff. So, in that sense there has been no confusion—the decision was reached in principle eight, 10 or 12 months ago. We decided to set up a service in the next financial year. That has been clear, and we have been able to get the money to underpin that.

[98] I do not have the statement in front of me, but my recollection of what was said, to clarify the point, was certainly that people in north Wales would have the choice of coming to Velindre or going to England, and that has always been the case. Clearly, if we are to develop a service in Wales, it is generally better for the resilience of the service that people in Wales use that service, because if we set it up and then people bypass that service, it ceases to be viable. However, from the very start we have said that, if people from north Wales feel that coming down to Velindre is too much, the commitment is there to allow them to go to the north of England. That has always been the case.

10.40 a.m.

[99] This morning, I said that, in the interim, Health Commission Wales would continue to look at individuals, particularly individuals for whom brachytherapy is the only treatment option, on a case-by-case basis until April. We have now been able to take a much more liberal attitude towards that and, hopefully, we will be able to fund everyone whose clinician indicates that brachytherapy is a suitable treatment—not the only treatment—for them. Hopefully, we will be able to offer them that service, which will be available in England. However, if people decided to travel from north to south Wales to attend the Velindre Hospital service, then they would be entitled to use the ambulance service as part of these new ambulance regulations.

[100] I do not know whether there is anything outstanding—

[101] **Jenny Randerson:** I think that some of the confusion is down to the difference between your interpretation of the situation and that of the First Minister. We have asked both of you about it and have received different answers. However, I welcome your clarification. Your statement was not specific, unless I misread it at the time, about north Wales, because many people raised the same concerns with me. However, it might be my mistake and I

welcome clarification on that.

[102] **Brian Gibbons:** I accept Helen Mary's point about independence. If the advocacy service is not just independent, but perceived to be independent by all the key stakeholders, then clearly its credibility and everything else will be at stake. Hopefully, the consultation will deal with some of these issues, but I am not sure whether the consultation document is out yet.

[103] **Helen Mary Jones:** The Minister said yesterday that it would be out next week.

[104] **Brian Gibbons:** A couple of models are outlined in the consultation document in terms of how the advocacy system might be seen to be independent. Nevertheless, if the feedback from the consultation indicates that none of this is sufficiently robust, then that is the whole point of the consultation—to test these ideas and see whether the particular models being proposed deliver that degree of robustness in terms of autonomy, independence and being free from influence and so on.

[105] I am aware of the national unit issue. Again, we must wait to see what the consultation tells us as to the precise form that that should take. Is that the hub from which everything should evolve or does it have to be some sort of co-ordinating or support centre or resource capacity? We must wait to see what the consultation tells us about that.

[106] **Helen Mary Jones:** Briefly, and I raised this point with the Minister responsible for children last night, in evaluating the responses to the consultation, we would urge the Government to bear in mind that many of those responding will have vested interests either in change or in the status quo. Therefore, in evaluating the different voices—and this probably goes without saying—we gave looked-after children the commitment that we would put that fact on record with you and that there would be an element, in people's responses, of asking the Government to think, 'Well, they would say that wouldn't they?'. I am sure that I am saying something that does not need to be said, but we offered to reassure them on that.

[107] **Rhodri Glyn Thomas:** Credaf, Weinidog, fod rhaid inni ddod â'r sesiwn i ben.

Rhodri Glyn Thomas: I think, Minister, that we must bring this session to a close.

[108] **Brian Gibbons:** Very briefly, Chair, I think that Helen Mary's analysis of the situation is correct. This report is produced by a consultancy group—no more than PricewaterhouseCoopers in Gwent. Those are the group's ideas and suggestions. The trust brought them in and will obviously evaluate what it says. The planning forum for the three counties will be where these more fundamental decisions will be taken. The consultants' report is a consultants' report.

[109] **Helen Mary Jones:** It is also clearly not designed to deliver by the back door.

[110] **Brian Gibbons:** No. It has to go through the planning forum.

[111] **Helen Mary Jones:** That is fine, thank you.

[112] **Rhodri Glyn Thomas:** Diolch yn fawr, Weinidog. Yr ydym wedi gor-redeg rhyw ychydig, felly awn am doriad yn awr a chymerwn eitem 3 ar ôl y toriad.

Rhodri Glyn Thomas: Thank you very much, Minister. We have overrun a little, so we will have a break now and take item 3 after that break.

[113] Hwn oedd adroddiad olaf y Gweinidog yn y Cynulliad hwn. Ar ran y

This was the Minister's final report in this Assembly. On behalf of the committee, I

pwyllgor, yr wyf yn diolch iddo am fod mor agored, hyblyg a gonest yn ei atebion. Mae hynny wedi gwneud y sesiynau hyn yn rhai defnyddiol iawn.

thank him for being so open, flexible and honest in his responses. That has made these sessions very useful.

Gohiriwyd y cyfarfod rhwng 10.45 a.m. ac 11.00 a.m.
The meeting adjourned between 10.45 a.m. and 11.00 a.m.

Rhestr o Is-ddeddfwriaeth
Schedule of Secondary Legislation

[114] **Rhodri Glyn Thomas:** Mae'r mân newidiadau wedi eu hamlygu yn ôl yr arfer, ond yr wyf yn eich rhybuddio nad oes gennym fawr o gyfle i edrych arnynt. Felly, os oes rhywbeth sydd yn pwyso yn fawr arnoch, neu os oes gennych rywbeth i'w drosglwyddo i'r trydydd Cynulliad, dywedwch yn awr. Gwelaf nad oes unrhyw sylwadau.

Rhodri Glyn Thomas: The changes have been highlighted as usual, but I warn you that we do not have much opportunity to look at them. Therefore, if there is anything that is pressing on your mind, or if you have anything that you wish to transfer to the third Assembly, please mention it now. I see that there are no comments.

11.01 a.m.

Is-ddeddfwriaeth: Rheoliadau Strategaeth Iechyd, Gofal Cymdeithasol a Lles (Cymru) (Diwygio) 2007
Secondary Legislation: The Health, Social Care and Well-being Strategies (Wales) (Amendment) Regulations 2007

[115] **Rhodri Glyn Thomas:** Nid oes pwyntiau o eglurhad neu welliannau wedi eu cyflwyno, felly nodwn hynny a symud ymlaen.

Rhodri Glyn Thomas: There are no points of clarification or amendments proposed, therefore we will note that and move on.

11.02 a.m.

Is-ddeddfwriaeth: Rheoliadau Cymorth Gwladol (Symiau at Anghenion Personol) (Cymru) 2007 a Rheoliadau Cymorth Gwladol (Asesu Adnoddau) (Diwygio) (Cymru) 2007
Secondary Legislation: The National Assistance (Sums for Personal Requirements) (Wales) Regulations 2007 and The National Assistance (Assessment of Resources) (Amendment) (Wales) Regulations 2007

[116] **Rhodri Glyn Thomas:** Mae gwelliannau gan Helen Mary Jones. Deliwn â hynny'n gyntaf.

Rhodri Glyn Thomas: There are amendments from Helen Mary Jones. We will deal with that first.

[117] **Helen Mary Jones:** I propose the following amendments. Amendment 1:

In section 4, the figure '£50,000' shall replace the figure '£22,000'.

[118] I propose amendment 2:

In section 5, the figure '£50,000' shall replace the figure '£22,000'.

[119] The proposed change reflects amendments that we have put forward on a number of occasions in Plenary. I felt that it was appropriate on this occasion to raise it with the Minister in committee.

[120] I will not rehearse the arguments at great length, Chair, because they are arguments that we have had on a regular basis. I begin by saying that we welcome the fact that there is a larger increase in the lower level, and we acknowledge that the Government has done that. However, the original purpose of this legislation when it first came in was to roughly reflect about half the cost of a fairly average family home. In communities across Wales, the value of an average family home has absolutely gone through the roof. The figure that we are proposing, which is £50,000, does not come up to that level, but it goes substantially further than £22,000. We realise that there are financial implications to this, but I would balance those against the social justice implications. It simply is not right that an elderly person who becomes very frail and needs care is not able to leave the same kind of inheritance to their children as someone who is lucky enough to die when in their nineties when they are still relatively fit and well.

[121] The original purpose was to allow ordinary people to leave an ordinary inheritance. I do not think that any of us particularly like means testing, but this legislation is means-test specific. In an ideal world, many of us believe that this care should be provided free of charge, which goes back to the discussions on the royal commission report that we have had in this committee and in predecessor committees on several occasions. We do not want to make those arguments today, but we believe that this figure needs to be substantially higher. I expect that the Minister will reject this on the basis of cost, and I understand that. However, I nevertheless submit this for discussion by the committee today, and I hope that, even if Members do not feel that they can support that figure, we can at least get an in-principle agreement that this is the direction in which we ought to be travelling.

[122] As I say, this is about fairness and about enabling people to leave a legacy to their families, which is particularly important when it is so difficult now for young people to get a foot onto the property ladder. I would also say that there are many substantially better-off people who know how to hide these things, and who, at a much earlier age, get advice from their accountants to transfer property and make arrangements that mean that, when they get to this position, they are not penalised in the same way as the average family.

[123] I do not propose to make the case at any more length, Chair. As I said, it is a discussion that we have had frequently.

[124] **Jonathan Morgan:** I wanted to ask the Minister a question, because Helen said that she thought that he would reject it on the basis of cost. I am sorry, Jenny, did you want to come in?

[125] **Jenny Randerson:** It is all right. I do not know why we bother putting them in.

[126] **Jonathan Morgan:** Well, I am deciding how I will vote on this. I agree with the spirit of what Helen Mary has said, but I would want to know what the budgetary consequences would be and I would want to be certain that what was being suggested was affordable. This is a serious amendment, and that is why I am asking the question. I was not going to put forward a point for clarification or an amendment, but, as this has been put forward for us to vote on, I would like to know the view of the Minister.

[127] **Rhodri Glyn Thomas:** To explain the process, we will deal with the points of clarification.

[128] **Jenny Randerson:** They are on the same issue.

[129] **Rhodri Glyn Thomas:** I understand that, but, because the amendments have been formally proposed, unless the Minister is going to agree to them, I will have to hold a vote on them.

[130] **Jenny Randerson:** I would like to put my points of clarification to the committee before you do that, because one of them is on exactly the issue that has been raised by both Jonathan and Helen Mary, and was designed to tease out the financial implications of the situation and the reason why the upper capital limit has gone up by significantly less than the inflation rate. The figure that you give for the inflation rate is either 2.7 per cent or 3.3 per cent. However, there are inflation rates floating around that are nearer to 4 per cent, depending on how you measure them. So, this does not keep pace with inflation despite the explanatory memorandum's saying that it does. There is also a point of clarification on the financial implications for local authorities. The explanatory memorandum suggests that it is just put in with the general local government pot and that local government expects this. The purpose of my raising that point is that we should know exactly how much money you specifically, as a Government, will put into the pot to cover this, because, if we go along with Helen Mary's amendments, that will have significant financial implications.

[131] **Brian Gibbons:** I will deal with Jenny's point first. It is a valid point. The reason why we find ourselves with this slightly lower figure is because the sums are generally rounded off to the nearest £250. So, we go up in blocks of £250. If the increase was 2.7 per cent, that would have brought us up to £22,081. If we round that off to the nearest £250, it brings us down to £22,000. So, it is just a matter of the rounding-off exercise. If it had been a bit higher, then the percentage increase could have been a little bit higher than inflation, just as an accident of the rounding-off process.

[132] If I may, Chair, I will deal with Helen Mary's points separately. In relation to the revenue support grant, the Assembly Government has signalled its intention in these areas over the last four or five years. As we have signalled our intention, the allocation that we give through the revenue support grant is, in part, to deliver on that particular commitment that we have given: in other words, that we would continue to look at the capital limits and that we recognise some of the specific circumstances that we face in Wales and that, where we can, and where we can afford it, we will be trying to reduce the charge and demands on people in line with what we can do under the law, because the law clearly requires local government to seek to recoup the costs of a residential home. That goes back to 1948. This principle goes back to the foundation of the welfare state. So, the fact that it is not specifically earmarked in the revenue support grant, but is in there, has been well signalled; this has gone on for four or five years. I believe that local government knows our commitment, and it expects us to put something into the revenue support grant to allow it to be able to meet the increased costs of this proposal.

11.10 a.m.

[133] On Helen Mary's points, I would urge you not to support this, which is no surprise. However, I understand the reasons that Helen Mary gave for her support. Her key point is that, originally, the thinking behind this £50,000 was that this represented the cost of a property for a low-income or a modest-income person. As she pointed out, the cost of these properties have significantly increased over the years. Therefore, effectively, if we follow the social justice argument, the only people who would, potentially, benefit from this are cash-rich people who do not have any property. They would be the main beneficiaries. If you have property—any property—then you will get caught, even in this £50,000, because the cost of the property has increased.

[134] Therefore, the only people who would benefit from the social justice point of view would be those who have relatively high cash savings and no property. People who have up to £50,000 or more cash savings, and no property, would generally tend to be better-off people. I do not believe that your average person who has been trying to save for the future would be likely to have accumulated anything like £50,000 in cash savings. The most common form of rented accommodation is council housing. Therefore, if we look at who the likely beneficiaries of this are, they will not be the people who Helen Mary, in her opening remarks, hoped that she would target.

[135] There is a considerable cost to this. Without going around and doing a census in every individual home, but taking some of the guidance information from the royal commission from a few years ago, this proposal could cost anything from £10 million to £15 million a year. Because of the changing pattern of property values, even if we wanted to go down the social justice route to do this, it seems that the place to put in the money is in lifting the floor rather than the ceiling. Increasing the floor by 7.8 per cent means that people with modest savings can keep a greater proportion. At present, what we are proposing means that someone with up to £17,250 in savings will have them protected. Increasing the floor means that at least the minimum amount of savings will be protected. Your proposal to increase the threshold at the top, Helen, means that the people at the bottom will not be protected, and the only people who will benefit will be those with big cash savings. Therefore, it will defeat the very social justice argument that you make.

[136] We have agreed the budget and the local government settlement. Anything from £10 million to £15 million will have to be found by local government to meet this bill, because it has statutory duties in this area. In terms of local government trying to deliver social services, or other services, it will not welcome suddenly finding itself having to find something like £10 million or £15 million, potentially, to meet these requirements.

[137] Therefore, I would urge the committee to reject this, on the grounds that it will not deliver a social justice dividend, but quite the contrary. If we want to spend £10 million in this area, I suggest that we spend it on increasing the floor rather than the ceiling. However, this is an uncosted expense for local government, and, as we have agreed the settlement with local government and agreed the budget, this is not the time to suddenly put this matter on the table.

[138] **Rhodri Glyn Thomas:** Cyflwynwyd y gwelliannau, ac felly, er eu bod yn gyd-ddibynnol i raddau, galwaf am bleidlais arnynt ar wahân, am eu bod wedi eu gosod ar wahân.

Rhodri Glyn Thomas: The amendments have been proposed, and so, although they are interdependent to a certain degree, I will call a separate vote on each, as they were set out separately.

Gwelliant 1: O blaid 1, Ymatal 3, Yn erbyn 2.
Amendment 1: For 1, Abstain 3, Against 2.

Pleidleisiodd yr Aelodau canlynol o blaid: The following Members voted for:	Pleidleisiodd yr Aelodau canlynol yn erbyn: The following Members voted against:
Helen Mary Jones	Brian Gibbons John Griffiths Lynne Neagle

Ymataliodd yr Aelodau canlynol:
The following Members abstained:

Jonathan Morgan
Jenny Randerson

Gwrthodwyd y gwelliant.
Amendment defeated.

Gwelliant 2: O blaid 1, Ymatal 3, Yn erbyn 2.
Amendment 2: For 1, Abstain 3, Against 2.

Pleidleisiodd yr Aelodau canlynol o blaid: The following Members voted for:	Pleidleisiodd yr Aelodau canlynol yn erbyn: The following Members voted against:
Helen Mary Jones	Brian Gibbons John Griffiths Lynne Neagle

Ymataliodd yr Aelodau canlynol:
The following Members abstained:

Jonathan Morgan
Jenny Randerson

Gwrthodwyd y gwelliant.
Amendment defeated.

11.16 a.m.

Is-ddeddfwriaeth: Rheoliadau'r Gwasanaeth Iechyd Gwladol (Treuliau Teithio a Pheidio â Chodi Tâl) 2007
Secondary Legislation: The National Health Service (Travelling Expenses and Remission of Charges) Regulations 2007

[139] **Rhodri Glyn Thomas:** Ni chyflwynwyd gwelliannau i'r is-ddeddfwriaeth hon, ond mae gennym bwyntiau sy'n gofyn am eglurhad. O gyfeirio'n ôl at yr hyn a ddywedodd Jenny Randerson, credaf y byddai'n rhwyddach, pan fo gwelliannau a phwyntiau am eglurhad, i ddelio a'r pwyntiau am eglurhad cyn y gwelliannau, am y gallent effeithio ar sut fydd pobl yn pleidleisio ar y gwelliannau. Mater i'r dyfodol yw hynny, fodd bynnag. Mae pwynt gan Helen Mary am eglurhad, ac mae gan Jenny Randerson dri. Mae Jonathan Morgan wedi ymddiheuro am fod rhaid iddo fynd i ddigwyddiad arall.

Rhodri Glyn Thomas: No amendments have been proposed for this item of secondary legislation, but we have points of clarification. Going back to Jenny Randerson's remarks, I think that it would be more convenient, when there are amendments and points of clarification, to deal with the points of clarification before the amendments, as they may have a bearing on how people vote on the amendments. That is a matter for another time, however. Helen Mary has a point for clarification, and Jenny Randerson has three points to raise. Jonathan Morgan sends his apologies as he has to attend another event.

[140] **Helen Mary Jones:** The point of clarification is before you, and it relates to Jenny Randerson's points. It concerns whether cancer patients will be able to claim travel expenses or are only eligible for ambulance travel. I am thinking in particular about long-term travel. Jenny Randerson refers specifically to brachytherapy, which she raised earlier and which I also had in mind.

[141] **Rhodri Glyn Thomas:** Gallwn gymryd tri phwynt Jenny ar yr un pryd, felly.

Rhodri Glyn Thomas: We can take Jenny's three points at the same time.

[142] **Jenny Randerson:** Points 2 and 3 were probably dealt with earlier this morning, or they will be dealt with by the answers to Helen Mary's questions. However, the first point is,

I think, a fresh issue, which is the advertising of these arrangements, because I think that most people are unaware of them. It is not easy; in some aspects, you have to get a certificate from the benefits office and so on before you make your claim. So, it is not something that you can suddenly claim afterwards; you have to prepare for it. The advertising of it is therefore the key to making it much more successful.

[143] **Brian Gibbons:** It is fair to say that there is not a very aggressive marketing of this scheme, but, having said that, I have been to many health buildings around Wales, where I see posters on the walls for this. If you look at the leaflet racks in GPs' surgeries or out-patient clinics and so on, you invariably see a copy of the booklet on reclaiming transport costs and health costs generally. A certain amount of information is there, but a number of things have been done in the past year to promote this scheme more effectively. For example, in October 2006, information posters and leaflets were produced and sent to all Jobcentre Plus offices in Wales as well as to Communities First offices so that they would be available for wider distribution in the community. In 2006 also, credit card dispensers were made available to draw the public's attention to this scheme, and these, too, were sent to pharmacists, dentists, GPs' surgeries, community health councils, Citizens Advice, NHS trusts and universities. Also, in the past year, a new round of posters has been made available, and these have been sent around to a range of health service and social care support agencies to make people aware of the scheme.

[144] There is a certain amount of publicity, and, from my experience, it is one of the most common posters that you will see on a public notice board in a health organisation, but it is not advertised in the way that, for example, tax credits are advertised. There is not a big media campaign with advertisements on the television or in the newspaper.

11.20 a.m.

[145] **Rhodri Glyn Thomas:** Credaf ein bod wedi delio â'r pwyntiau o eglurhad.

Rhodri Glyn Thomas: I think that the points of clarification have been dealt with.

[146] **Helen Mary Jones:** My point was about whether patients were eligible for travel expenses other than ambulance travel expenses. We need to clear that up. I understand from what the Minister said that they would be eligible to claim train fares or whatever but—

[147] **Brian Gibbons:** Well, people who need dialysis or cancer treatment are entitled to get an ambulance. People outside that category are entitled to take advantage of this scheme on a means-tested basis.

[148] **Helen Mary Jones:** So, the person travelling from north Wales to Velindre for brachytherapy using the train might be entitled, on a means-tested basis, to claim the cost of his or her train travel. Is that right, Minister?

[149] **Brian Gibbons:** Yes, that is right. He or she would have the option of using an ambulance, obviously, but if they chose not to do that and if they were eligible under the means-testing, then—

[150] **Helen Mary Jones:** I will just make a broader point on that, if I may. In terms of the future of the ambulance service, there is an anomaly here. You can get your ambulance travel from Conwy to Velindre for your brachytherapy treatment completely free and we could argue about whether that is a good use of ambulance service time. That is non-means-tested. Is that right, Minister?

[151] **Brian Gibbons:** Yes.

[152] **Helen Mary Jones:** Brachytherapy is a good case in point because it is such a non-invasive treatment that it would be perfectly possible, if you had somebody travelling with you, to travel down by car or train, have the treatment done and go back the next day or whatever. That is only affordable on a means-tested basis. I just want to flag up for the future that, as the modernisation plans of the ambulance trust roll out and as we make a clearer difference between patient transport aspects and emergency aspects, I certainly do not think that we would want a paramedic to spend her or his time driving an ambulance from Conwy to Velindre.

[153] **Brian Gibbons:** Oh, no. I do not think that we envisage, even with the ambulance, the use of a paramedic under this scheme, unless—

[154] **Helen Mary Jones:** It is also an issue of comfort though. You will probably not want to be—

[155] **Brian Gibbons:** Alan Murray said here at committee that for many of these transport issues, he was looking to provide, wherever possible, individual patient—

[156] **Helen Mary Jones:** Cars or minibuses where there are groups.

[157] **Brian Gibbons:** Yes, that is right. In practice, in some of these instances, the ambulance will contact the individual and say to them, 'If you are fit to travel, we will arrange for you to go by bus or train, or whatever. Do you really want an ambulance to bring you?'. So, there is an element of pragmatism in this and, in practice, the pragmatic dimension comes into play and people are asked whether they want an ambulance or whether they are willing to go by train or whatever and we then pay the cost of that.

[158] **Rhodri Glyn Thomas:** Mae'r Gweinidog wedi rhoi ateb llawn i'r pwyntiau o eglurhad.

Rhodri Glyn Thomas: The Minister has fully answered the points of clarification.

11.24 a.m.

Deintyddfeydd Preifat—Adroddiad Dichonoldeb o dan Reol Sefydlog Rhif 31
Private Dental Practices—Feasibility Report under Standing Order No. 31

[159] **Rhodri Glyn Thomas:** Fe gofiwch fod hyn yn deillio o'r ffaith bod Tamsin Dunwoody wedi ennill y bleidlais ar gyfer is-ddeddfwriaeth o dan Reol Sefydlog Rhif 31. A oes pwyntiau i'w codi ar y mater hwn?

Rhodri Glyn Thomas: You will remember that this emanates from Tamsin Dunwoody's winning of the ballot for secondary legislation under Standing Order No. 31. Are there any points to raise on this mater?

[160] **Jenny Randerson:** I have one point. I am sure that the Minister is aware that we have received a very full submission from the British Dental Association stating that this proposal is unnecessary and overly bureaucratic. I am concerned about anything that is labelled 'overly bureaucratic' and I would like to hear the Minister's comments on the BDA's response that questions why we are going for additional work when there is all this inspection already. What are the real risks that this legislation will address?

[161] **Brian Gibbons:** I do not think that that is an accurate summary of what the BDA said. I think that the BDA did concede and accept it, because I met Stuart Geddes to discuss this issue, among others. The association agrees that it is a good thing that there is an inspection process, so it is not against that in principle. What the BDA is arguing in its paper is that this is a disproportionate response to an inspection process. That is its view at this

juncture.

[162] On the process that we are going through at the moment, this is a feasibility study and the next step would be to consult with key stakeholders, such as the BDA, as long as we agree that the feasibility study is the basis for moving this agenda item forward. The next step would then be to start formulating the regulations. At that stage, we would need to engage the BDA and other key stakeholders in relation to the formulation of those regulations. Once the regulations are drawn up, there will have to be a formal consultation process on that.

[163] You may remember that there was a consultation process for Huw Lewis's debate under Standing Order No. 31. There are two things to note about that. You may recall that it started off requiring medical examinations for looked-after children but became one of the most comprehensive child-protection changes that the Assembly had undertaken. So, that gave us the impetus to look at a much wider range of things, and there was a massive consultation process around that.

[164] In this process, there are two stages at which we would expect stakeholders, such as the BDA and other professional representational organisations, to have an input: in the phase prior to drawing up the regulations, they would make a formal response to the consultations; and, after that consultation exercise, they would have an input to the final laying of those regulations. I think that we are about two or three steps away from this becoming law.

[165] **Jenny Randerson:** That is fine, thank you.

[166] **Rhodri Glyn Thomas:** Mae'r pwyllgor yn hapus y bydd digon o gyfle i ystyried y pwyntiau hyn yn y camau a fydd yn dilyn, felly nid oes galw arnom i wneud mwy ar yr adeg hon.

Rhodri Glyn Thomas: The committee is happy that there will be enough opportunities to consider these points in the stages that are to follow; therefore, there is no need for us to do any more at this point in time.

11.28 a.m.

Cyflwyniad gan yr Asiantaeth Safonau Bwyd
Presentation by the Food Standards Agency

[167] **Rhodri Glyn Thomas:** Croesawaf Joy Whinney a Hilary Neathey a'u gwahodd at y bwrdd. Mae'r asiantaeth wedi cyflwyno adroddiad i ni, sydd ger eich bron. Yn garedig iawn, mae wedi darparu nodiadau'r cyflwyniad PowerPoint—ni fydd y cyflwyniad PowerPoint yn cael ei roi ond mae'r nodiadau gennych. Fe'ch gwahoddaf i gyflwyno eich sylwadau.

Rhodri Glyn Thomas: I welcome Joy Whinney and Hilary Neathey, and invite them to sit at the table. The agency has presented a report to us, which is before you. They have kindly provided the notes for their PowerPoint presentation—we will not be seeing that PowerPoint presentation, but you have the notes. I invite you to comment on your paper.

[168] **Ms Whinney:** Thank you for inviting us today to talk to you about the Food Standards Agency's role in dietary health and consumer choice. I very much welcome the opportunity to discuss some of the issues with the committee. The copies of the slides that you have been given are intended to be generally helpful, but are not essential; if you do not find them helpful, please do not worry about them. Although we have been asked to talk about dietary health today, the FSA was born out of a crisis in food safety, with the lack of consumer confidence in food and the safety measures that were in place. I just wanted to say, right at the outset, that, although we are doing a lot of work in the nutrition area, food safety is still very much the focus of the Food Standards Agency—we are not going to take our eye

off that ball. Since we were set up in 2000, cases of food poisoning have been cut by 19.2 per cent, we now have virtually no salmonella contamination in UK-produced eggs, and our consumer surveys show us that, generally speaking, consumer confidence in food and the regulatory framework is fairly high at the moment. However, we obviously need to continue to make that a priority.

11.30 a.m.

[169] There is a good risk-based case for putting effort into improving nutrition: whereas food poisoning causes around 500 deaths a year in the UK, and food allergies around 20, I am sure that this committee is aware that a third of deaths from coronary heart disease and a quarter of deaths from cancer can be attributed to poor diet. In Wales, that accounts for more than two thirds of all deaths. I am not going to go into all the detail of the areas of health inequality in Wales, poor diet and what all that means, because the committee is well aware of the health picture. However, I am hoping to outline some of the areas of work that the FSA is engaged with, and, I hope, convey to the committee the important supporting role that the FSA can play in delivering the Assembly's health improvement agenda.

[170] I am quite happy if people wish to interrupt me as I go, but otherwise I shall just carry on.

[171] **Rhodri Glyn Thomas:** If you give your introductory remarks, we can move to comments and questions from Members.

[172] **Ms Whinney:** Right. The first diagram in the presentation is the message frame for our approach to improving diet and health. The main message is that our approach is to try to improve people's diets in Wales and the UK by making healthier eating easier. There are a number of approaches through which we can achieve that, one of which is to change products. That involves working with the industry to reformulate products. So far, that has been done with salt, but we are now looking at fat and saturated fat, and hoping to persuade the industry to reformulate its products to make food healthier.

[173] The next approach is to influence people and to make healthier choices easier. That involves initiatives such as the agency's front-of-pack signposting scheme, which has traffic-light colour coding to make it easier for people to distinguish foods that are healthier and should be eaten more often. The other pillar of our approach is to influence the environment and remove barriers to making healthier choices. In practice, this is the area on which the Welsh Assembly Government takes the lead in Wales, and we see ourselves as being in more of a supporting role, for example, on activities in schools, school lunch standards and the promotion of foods to children, which the health department takes the lead on. That is the framework.

[174] I also wish to show you some of the major work that we have been doing. We are active at the European Union level; the agency negotiates in Europe on behalf of the UK. Most food legislation is set at the European level, as you will know. For matters such as labelling, health claims and allergen issues, what is agreed at the EU level sets the framework within which we operate when trying to improve people's diets in Wales and the UK.

[175] On reformulation, the work that we have been doing with the food industry on reducing salt has been fairly successful. All sectors of the food industry have been engaging with this agenda, and have responded positively. To give a few examples, the average amount of salt has fallen by about a third in pre-packed sliced bread, in soups and sauces, and in breakfast cereals. Heinz has reduced the level of salt in it is baked beans by about a third; McCain has halved the salt content of some of its products; all Birds Eye ready meals now contain less than 2g of salt; and half of Tesco's own-brand products already meet the FSA's

voluntary salt targets. That was a bit of an advertisement for various companies. [*Laughter.*] However, if you would like to see any more information about the exact targets that have been agreed with the different manufacturers and retailers, all the information is on the FSA website.

[176] The FSA's approach is to work with consumers on the one hand, through our salt campaign, which raises awareness of the need to cut down on salt because it reduces the risk of hypertension, and subsequently the risk of coronary heart disease or stroke. So, through that campaign, we are creating a demand for lower salt products on the one hand, and, on the other, we are working with the industry to provide those products. So, we hope that that circular process reinforces the message.

[177] Since we started the salt campaign in 2004, we have certainly seen a significant increase in people's awareness in Wales of the need to reduce salt in their diets. People are telling us that they are trying to cut down on salt and that salt is one of the major things that they look for on food labelling. Of course, there is a difference between what people say they are going to do and what they actually do. We are engaged in research to check urine salt levels, so we will have a biological marker of how we are doing, and we hope to see some improvement in what people are eating.

[178] There is also some limited evidence to suggest that people are buying less salt, although I have been cautioned about this, because people also throw it on the pavement when it is icy and so that could be an indication of a mild winter rather than of people cutting down on salt. We will continue to monitor that.

[179] Another major issue for us this year is the consultation on folic acid. As you may be aware, the Committee on Medical Aspects of Food and Nutrition Policy concluded, back in 2000, that fortifying flour with folic acid would significantly reduce the number of pregnancies affected by neural tube defects, such as spina bifida. Although the data from the UK countries are not collected in a completely consistent way, the rate of neural tube defects in Wales is significantly higher than it is in England. We know that that is partly down to much better reporting, but there may also be a genetic factor, so it is an issue of interest in Wales.

[180] We are currently consulting on four options. The first is to maintain the status quo, namely to continue the current policy of advising all women who are planning to get pregnant to take folic acid before conception and during the first 12 weeks of pregnancy; the second would be to greatly increase our efforts to encourage young women to take folic acid supplements and to increase their consumption of naturally folate-rich foods; the third is to encourage the food industry to fortify more foods with folic acid voluntarily; and the fourth is to recommend the mandatory fortification of bread or flour with folic acid. It is the fourth option that the Scientific Advisory Committee on Nutrition favours, but we are consulting on all four options. The Food Standards Agency board will consider the advisory committee's report and the input that we receive from the Chief Medical Officer for Wales, among others, and prepare advice to health Ministers on which option to follow—that will be after the FSA board meeting in May.

[181] A lot of work is also going on in Wales in support of the Welsh Assembly Government's health improvement agenda. I will mention some examples of tools that we have provided. We have worked on target nutrient specifications for manufactured products used in school meals, to help caterers to meet the forthcoming nutritional targets for school meals. We have helped caterers with training and worked on training standards for nutrition and catering, which would cover school meals. We have done a lot of work with the Assembly on healthy drinks vending and setting up fruit tuck shops in schools, and have done research that has influenced the work on 'Appetite for Life', which looks at what influences

school pupils' choices and whether the availability of choice alone would result in a healthier diet, and so on. We are now working on our response to the curriculum review, because, like many others, we believe that it is important to take a whole-school approach and ensure that children are educated about food issues, healthy eating and food safety. We are currently looking at the curriculum in that regard.

[182] I will stop there, but I am happy to take any questions on what I have said or on anything to do with food safety.

[183] **Lynne Neagle:** The traffic-light scheme has been running for a while. Have you undertaken any detailed analysis of the impact of it? Do you feel that it is operating in a way that complies with your guidance? How is it impacting on shoppers' habits? There are quite a few retailers that are still not complying with the format that you have recommended. Do you feel that the Government should be taking further action in relation to that, and should such a scheme be made statutory?

[184] **Ms Whinney:** A number of major retailers and manufacturers are following the agency's recommended scheme, which basically consists of the colour-coded traffic lights and telling consumers whether a product has a high, medium or low level of particular macronutrients, namely fat, saturated fat, salt and sugar, which we need to cut down on. So, many retailers, including Sainsbury's, Waitrose and the Co-op, are following such a scheme. There are others that are using the colour-coded traffic lights in a way that would meet the agency's recommendations, but are also providing the guideline daily amount. There are others, such as Tesco and Morrisons, that are just using the guideline daily amount approach. We have come quite a long way in a couple of years, because, previously, all this information was hidden away on the back of packs. So, even though there is not complete consistency yet, we have at least got to a stage where nutritional information is clearly displayed on the front of processed food packs, and we think that that is a step in the right direction. There is a steering group that comprises all the sectors of industry that are currently taking different approaches.

11.40 a.m.

[185] An independent research project is currently being undertaken to look at how this influences people's behaviour, and it has been described as the biggest market research project ever, because, basically, we have 56 million subjects involved, and we are looking, over the next year, at the difference that these schemes can make to consumer choices. The research that we have undertaken so far, in making our recommendations, suggests that people like a colour-coded approach, which they find helpful. It also suggests that people find percentages difficult, which is why we have gone for the scheme that we have. Having said that, if the independent research, which everybody has signed up to, shows that the other approach is having a greater effect and making people eat healthier, then that is fine; we will go for the other approach. From the work that we have done so far, we do not expect that to happen, but the good thing is that we have everybody signed up to that independent evaluation. By next year, we should be able to say what has worked best and, hopefully at that stage, people will fall in line and follow an approach.

[186] The slides that have been sent around show one option for greater consistency in that some of the retailers, such as Marks and Spencer and McCain, are using the colour-coded traffic lights and the GDA. You could, therefore, argue that, if everybody went for that, then everybody might be happy, but we will wait to see how that goes.

[187] **Jenny Randerson:** I want to follow up on the traffic-light scheme; I was delighted to see, this week or last week, some research showing that Tesco shoppers—Tesco does not use the traffic lights, of course—found the traffic-light scheme easier. One of the first things that

you learn as a politician, and something that I know well to be the case from my time as a lecturer, is that most people do not understand percentages; yet, there can hardly be a person in the country who does not understand the concept of traffic lights. There is also an issue of whether you can see; as someone with slightly failing eyesight in middle age, putting one's reading glasses on and taking them off all the time to be able to read what is on the pack is a pain, and you actually do not bother to do that in most cases. However, most people can see colours well enough, so we have to make it as simple as possible. I would like to take up Lynne's third point with you, about the possibility of moving to legislation on this matter. The situation currently is that people have a confusing array of schemes, as you have just illustrated for us, and surely, uniformity and simplicity have to be the main thing.

[188] On a separate and different point about school meals, I do not want to enter into the wider issue of healthier school meals, which we have discussed before and which I think we all accept, but you talked about your work on school meals, and I hope that that specifically includes salt levels. One of the issues is that people get used to a certain level of salt, do they not? You must educate children's palates to expect relatively little salt, so that very salty food then tastes unpleasant to them. Are you working on salt levels?

[189] **Ms Whinney:** It is covered in the 'Appetite for Life' recommendations, which the Welsh Assembly Government is taking forward. It has been tackled by us through these target nutrient specifications, which definitely cover salt. That means that, if you adopt those specifications, then the specification that you put out to your suppliers will have certain levels of salt, above which you will not accept the supply. That would then help school caterers or the local authority to meet the overall nutrient specifications in the 'Appetite for Life' recommendations.

[190] On the possibility of legislation, we hope that the traffic-light approach, or whichever approach turns out to be most effective, will be adopted voluntarily, because that is quicker in making the system available to people. If not, we would have to go through Europe to introduce it, because it would fall within the competence of an area already covered by labelling legislation at the European level. However, we have maintained close contact with the commission on this matter, and there is a lot of interest in signposting around other European member states, as, indeed, there is in the US and Canada. So, it is something that will be looked at in the labelling review that is going on in Europe at the moment.

[191] **Helen Mary Jones:** I have a comment on something that I think that you are doing right. The promotional work that you do with the comedy shows at the eisteddfod and the Royal Welsh Show, mainly targeted at children, is having a real effect in terms of awareness of food safety and some healthy eating issues; I say this as a parent who has been castigated by my daughter for putting things in the wrong part of the fridge after she learned lessons from your shows. It is a compliment to you that some of those innovative approaches for getting messages across can often work more effectively than banging people over the head.

[192] **Ms Whinney:** Thank you; that is appreciated. Pester power is a major factor in all of this, I think.

[193] **Ms Neathy:** We are hoping to develop lesson plans around the type of pantomime that you have seen on the trailer, so that when children come to visit us with teachers, they can have some pre-trailer and post-trailer activities that link into the curriculum.

[194] **Ms Whinney:** That also helps us to evaluate the effect that it has had. At the moment, we only have figures on how many thousands of kids have seen it and have been through the trailer—it is difficult to grab them and work out what they have learned from it. It will be easier to do that through the school.

[195] **Rhodri Glyn Thomas:** Os nad oes cwestiynau neu sylwadau eraill, diolchaf i'r ddwy ohonoch am gyflwyno'r adroddiad. Fel pwyllgor, yr oeddem yn awyddus i dderbyn adroddiad ar eich gwaith a bu'r ddeialog honno'n werthfawr.

Rhodri Glyn Thomas: If there are no other questions or comments, I thank you both for presenting the report. As a committee, we were keen to receive a report on your work and that dialogue has been valuable.

11.47 a.m.

Adroddiad y Comisiwn Hawliau Anabledd ar Anghydraddoldebau Iechyd
Report of the Disability Rights Commission into Health Inequalities

[196] **Rhodri Glyn Thomas:** Mae gennym broblem fach gan ein bod ychydig o flaen ein hamser. Yr oedd aelodau o Gomisiwn Hawliau Anabledd Cymru yn awyddus i fod yma i ymateb i'r eitem hon, ond gan mai ymateb y Llywodraeth sydd ger ein bron, gofynnodd y pwyllgor i'r Gweinidog yn benodol ymateb i'r adroddiad. Gwn fod Lynne Neagle am godi rhai pwyntiau ar y papurau i'w nodi. Cymerwn y pwyntiau hynny a phwyntiau Jenny Randerson yn gyntaf, gyda chaniatâd y Gweinidog; gan nad yw wedi derbyn rhybudd am y pwyntiau hyn, hyd y gwn, caiff ddewis ymateb ar lafar neu ddarparu nodyn yn ddiweddarach.

Rhodri Glyn Thomas: We have a problem in that we are slightly ahead of schedule. Members of Disability Rights Commission Wales were keen to be here to respond to this item, but, as it is the Government's response that is before us, the committee specifically asked the Minister to respond to the report. I know that Lynne Neagle wishes to raise some points on the papers to note. We will take those points and Jenny Randerson's points first, with the Minister's permission; as he has not received prior notice of those points, as far as I am aware, he can choose to respond orally or to provide a note at a later date.

[197] **Lynne Neagle:** On the Townsend paper, I thank the Minister for providing an update. While the regional figures that we have been given are helpful, we are interested in the way in which it impacts on individual LHBs. If you look at south-east Wales, point 8 of your report says that it is now 0.7 per cent over target, yet we know that a good number of individual LHBs are below target in terms of the Townsend formula; two local health boards in Gwent, in particular, are well below target, namely Torfaen and Caerphilly. Therefore, it would be helpful to know how the regional adjustments will impact on the people who are still waiting for the full implementation of the Townsend formula.

[198] **Brian Gibbons:** The problem that we have is a question of how reliable the figures are below regional level. When we looked at it, it seemed that there may have been an effect of small numbers and that there was considerable variation. One of the reasons why we asked for the independent review and the expert group was because we were concerned that we were getting a lot of noise rather than accurate data in relation to the figures at a local health board level. If we say that much of the information that we see at local health board level could be noise rather than a clear signal, I would be reluctant to start giving figures, because once you start giving figures, it starts to give credibility to things—I think that you create hostages to fortune. If we say that we are not convinced that the data that we are talking about is robust enough, I do not think that it would be helpful to give figures.

11.50 a.m.

[199] **Lynne Neagle:** I understand what you are saying about the accuracy of the data, and I am not asking you to interpret the data that these allocations are based on, but you must have some figures for how the extra money that you are allocating to south-east Wales is going to impact on individual LHBs. There must be a way of going below that and seeing what that extra money will mean for the Townsend gainers and losers within the south-east Wales area.

You must have those figures.

[200] **Brian Gibbons:** Yes, but if you are asking how far those figures are from the target level, that is what becomes difficult. It is difficult to work out what the target should be with smaller levels of statistics, because the margin of error increases as the population size decreases, which is what happens when you get down to the level of local health boards. It is not difficult to tell you how much extra Torfaen, for example, will receive because of this allocation; that would not be difficult.

[201] **Lynne Neagle:** That is what I want, but it should also be possible to say how far those figures are from the old Townsend targets, should it not? If you can say that south-east Wales is 0.7 per cent over target, you should be able to say where the LHB figures are in relation to those targets.

[202] **Brian Gibbons:** That is the problem. The reason why we have taken the regional approach is that we think that, for statistical reasons, the calculation is probably reasonably reliable at a regional level, because of the population size. However, once we start going below regional level, particularly to small local health board areas, then the margin of error starts getting bigger and bigger. It may be that within that margin of error there is a true figure, but equally it is possible that we may get an erroneous message. So, giving you the actual sum of money is not a problem, but in terms of giving you the benchmarking against Townsend—I suppose that it would be possible to tell you what that would be, compared with the figures that Townsend was originally based on in, what was it, 1997?—I do not know whether our statistics people could do that. I think that you would want to put one hell of a big health warning on any such figures, because you are asking what this means for a formula that was based on data from nine years ago.

[203] **Lynne Neagle:** It was not nine years ago; it was 2001.

[204] **Brian Gibbons:** The data for 2001 was collected in 1997. So, you would be making the calculation on a 1997 database.

[205] **Rhodri Glyn Thomas:** We cannot really go into an extended debate on all these points. They should really be requests, and if there are specific issues arising, the Minister should have been notified beforehand so that he can respond. We will have to move on to the next point.

[206] **Lynne Neagle:** I have a query on the telephone charges paper. There is a table on the trusts' public telephone income, and I wanted to clarify exactly what that means. Does it mean both payphones and things like Patientline, or is it just Patientline? Obviously the big concern is around things like Patientline rather than public phones, which I think people accept that they must put money into, but I wondered if we could have some clarification about that.

[207] **Brian Gibbons:** It is for all public phones, including portable and fixed landlines.

[208] **Lynne Neagle:** So, is it possible to have some information for things like Patientline separately? I think that payphones are a different kettle of fish altogether.

[209] **Ms Lloyd:** I will print it out for you.

[210] **Brian Gibbons:** Patientline is a sub-section of that total, so whatever it costs, it is obviously less than the total there. The total given there includes everything, including fixed phones.

[211] **Rhodri Glyn Thomas:** Could we have a note of that, Minister?

[212] **Brian Gibbons:** Yes.

[213] **Jenny Randerson:** My question is really more of a comment on the fact that, yesterday, we dealt with the in-year transfers in Plenary, and today we have the paper on it. I have concerns at the timing of this, Chair. As finance spokesperson, I attended a briefing given by the officials of the Finance Minister, who said that it should all have come to committee before. So, my comment is on the timing and not on the content.

[214] **Rhodri Glyn Thomas:** Many of us would share your concern.

[215] We are now pleased to welcome members of the Disability Rights Commission. We are discussing the Minister's response to the report on health inequalities. The committee requested that the Welsh Assembly Government place a paper before us in response to the recommendations made in the report. We have that paper. Do you want to introduce it formally, Minister?

[216] **Brian Gibbons:** No, I think that it is a pretty comprehensive response.

[217] **Rhodri Glyn Thomas:** Okay, I will take comments or questions from the Members first, although I know that the commission has issues that it wants to raise. We will go to Helen Mary first.

[218] **Helen Mary Jones:** I thank the Minister and his officials for this. However, it is interesting to note that up to the response to recommendation 4, this paper gives us some specific targets and timings for when you will do something, but after recommendation 4, it becomes much more vague. For example, the response to recommendation 5 states:

[219] 'The Assembly Government will highlight in its forthcoming policy guidance relating to community mental health teams the importance of ensuring that peoples' physical health is monitored'.

[220] Earlier, with regard to similar bits of advice and guidance being issued, you tell us when you will issue it and when we should expect to receive it. So, this is a pretty comprehensive report, but it switches gear halfway through from telling us exactly what you will do when and how, to becoming a bit less specific. There must be target times and deadlines for all these things. I say that in the spirit of accepting that those can sometimes slip. For example, if you end up with a complex piece of legislation for a particular department to deal with, then the issuing of a particular set of guidelines can slip. However, it would be useful for us, at some point, to know the deadlines.

[221] **Rhodri Glyn Thomas:** I will stop you there, because perhaps Phil can explain the nature of the paper and why you have this impression that, as the paper goes along, the targets become vague.

[222] **Helen Mary Jones:** They disappear: the word 'target' is not used after recommendation 4.

[223] **Mr Chick:** There is an issue in that the more comprehensive responses given at the beginning of the paper would be duplicated, because some of the initiatives that are taking forward a response to the recommendations of the DRC's report are picked up in the earlier recommendations. So, the quality and outcomes framework and the improvements in primary care address a number of those recommendations, particularly those around physical health checks. Given that they re-emerge in the document, it could get repetitive, so some of the

earlier answers can be read across to the other recommendations, particularly those around physical health checks, and are addressed a number of times throughout the paper.

[224] On the development of the work on the community mental health teams, that will follow on from the policy implementation guidance that has been issued on primary care, which goes into considerable detail about physical health checks for people with severe and enduring mental health problems. The expected publication date for the CMHT policy implementation guidance is around April or May. It is in draft form and we are consulting with constituencies around Wales on its content, and that will relate back from the role of secondary care to primary care colleagues. Therefore, again, it covers some of the ground in terms of the primary care issue, but there will be read-across between those two documents.

[225] **Helen Mary Jones:** That is helpful, but if I were a member of the general public picking this document up from the website, I would not be able to see that read-across. I know that when one is drafting these documents—speaking as someone who had to do so in a previous existence—it can be very repetitive to have to say, 'Please, see our response to recommendation x', but for those reading the document, it can be helpful. I could see some of that read-across, as I went through the document, but there would be something wrong if I could not. It is a general point that, even if you repeat yourself, sometimes that is necessary for the sake of clarity. However, I am encouraged by what Phil has said.

12.00 p.m.

[226] My other comment is specifically on recommendation 11 on training. This is the one point where it struck me, and I am sure that colleagues from Disability Rights Commission Wales will be able to tell us more, that the Government's response is not adequate. There may be other things that I have not picked up that colleagues will be able to highlight. Recommendation 11 is a clear recommendation that includes involving service users and user groups in the design and delivery of training. The Government's response begins by saying that it accepts the recommendation, which is excellent; I am pleased to hear that and I would expect nothing less. However, the response to the recommendation does not tell me how user groups will be involved in the various bits of training. When it comes to anything to do with disability, when I see the phrase:

[227] 'The NHS CEHR will, as far as is practicable, incorporate into its training and development',

[228] I get little prickles at the back of my neck, because I cannot think of an occasion when it is not practicable, particularly with regard to the design of training materials. I can think of occasions when it might not be possible in terms of delivery, but I cannot think of anything that is not practicable. In a previous existence, I have worked with many organisations that would tell you that almost nothing around good equality practice was practicable, were they allowed to get away with that. So, I am concerned. The comprehensive programme of training is addressed, but the issue within the recommendation about the involvement of users and user groups is not adequately addressed. It may well be—and I hope that this is the case—that this is something that is intended or that will happen but has not been spelled out sufficiently. However, because many organisations find this challenging to do, and because, particularly around disability equality, it is so important, we need some clarity on that today, and perhaps it needs to be spelled out.

[229] **Brian Gibbons:** I will ask Ann to go into more detail. As I understand it, EquIP Cymru, if not totally a voluntary sector organisation, is made up of or has an input from that sector. So it has had that built into it as an organisation from when it came into existence, and that clearly has to be fed across into primary care, as EquIP delivers its access programme and so forth. As far as the knowledge and skills framework is concerned, the whole point of it is

to involve users and carers in the process. As well as conveying information and improving skills, part of the process of doing that is how you engage with the people who are most affected by it as part of your learning mechanism.

[230] **Ms Lloyd:** It is a valid point. We all understand the words here, but if you were just a user, could you understand what the effect would be? As part of the equalities schemes, which are mandatory for health bodies and their partners, there will be a requirement that they ensure that everyone with whom they contract complies with them. As part of that, they must put into being a proper training and development programme for all their staff, which will be underpinned by the various knowledge and skills frameworks. The knowledge and skills frameworks that we are using, as the Minister said, place considerable emphasis on how to involve users effectively, and that is underpinned by the new information that we are putting out about engaging users more effectively as part of the advance of the national service frameworks that we have been developing. So, we need to rephrase this. NLIAH and its associates will be leading the implementation of the knowledge and skills framework, particularly to address the requirements of the disability and other equality schemes required of the NHS in Wales. We will reinforce and slightly change the wording of this to make it clearer what requirements are placed on the NHS and its partners to achieve this.

[231] **Jenny Randerson:** Helen has covered one of my points, which was my disappointment at the lack of specific targets. My second point is in relation to recommendation 1 and the issuing of guidance to general practitioners on complying with the Disability Discrimination Act 1995. How much priority is given to this issue when bids are made for funding? The Minister will know that I have questioned him about the funding of improvements to GP premises in the past, and I am concerned that that there may be premises that are not DDA compliant—in fact, I am aware of such premises—and which are lost in the maze of local health board plans and sub-groups, the Assembly Government forum, and so on.

[232] **Brian Gibbons:** As I understand it, overwhelmingly, priority is given in the improvement grants for GP premises to allowing practices to become DDA compliant. So, in fairness, it is difficult for bids that are not about delivering DDA compliance to get onto the starting track at the minute. That is not to say that every single bid for DDA compliance has been met, which is a slightly different thing, but the improvement grants are very heavily skewed towards delivering DDA compliance. I do not know whether we could get some specific figures on that. That might be helpful.

[233] **Dr Watkins:** We can certainly ask.

[234] **Brian Gibbons:** We will see whether we can get some figures on that.

[235] **Rhodri Glyn Thomas:** We now turn to the Disability Rights Commission. Will, would you start?

[236] **Mr Bee:** We have provided the committee with a paper that summarises the response of the non-Assembly bodies, and, universally, from the Assembly and by bodies outside it, there has been a positive response to the formal investigation. Organisations have taken the recommendations seriously and are acting on them with considerable speed. It was only in October that we were here introducing the report, so, overall, I would say that responses have been very positive. Some things that the Assembly has said that were in the pipeline have been confirmed in its response, and we are pleased to see things such as changes to the GP contract and the annual health checks. However, related to that, a new commitment to monitoring the process and the effectiveness of it is important, and the support for the EquIP Cymru training programme is also welcome. In addition, on the commitment to a national strategy to reduce health inequalities, we had not been led to expect that that would

necessarily come forward, and we are pleased to see that. The new health-gain targets are again a very positive and pleasing response on what we might have immediately expected.

[237] We have identified four areas in the Assembly response that we are a little concerned about, and where we hope to see a more robust programme, although we recognise that it is still early days. In the absence of a national service framework for learning disability, we identified that we were looking for clearer guidance in the field of learning disability, particularly in the health sector. The response identified guidance on service principles and responsibilities, but it is very much focused on the local authority social services side of affairs, and we are keen to see this fed across into the health side. There can sometimes be more of a divide than one would like between the two services, and we would like to see the approach set out in the guidance principles read across. We identified and acknowledged that this is a tough nut to crack, that the lessons learned from local initiatives and pilot programmes can often get lost, and there is no clear mechanism for taking that forward. We note that NLIAH is positive and keen about taking this forward, however, we are looking, over time, to see some really practical measures to hold a clear record of what has been demonstrated to work and a co-ordinated programme, which should be rolled out on a Wales-wide basis, to see that happen. If there was an easy way to do it, we would have made recommendations along those lines. We acknowledge that it is hard.

12.10 p.m.

[238] Recommendation 6 on the provision of healthcare and healthy living for those in institutional settings is another area where we acknowledge in the paper that clear standards are set out in inspection regimes and regulations. However, all of these were in place, by and large, when we did the investigation and yet the problems are still coming through. It is challenging to make those stick. What we have not yet seen in the response are practical steps that will make them stick. Again, if it was easy to do, we would have made recommendations to that effect. We want to see the Assembly bending its mind to do that over the next period in taking forward our recommendations.

[239] Finally, with regard to our report finding relating to bowel cancer in patients with schizophrenia, we have been disappointed that it has not been taken forward not only in terms of the screening programme, but in terms of feeding into other health promotion and healthcare strategies. We want to see more attention being given to that in taking it forward. We will be reconvening the inquiry panel over the summer and will be sending to the Assembly the inquiry's recommendations on how to take it forward. Overall, we will see a positive response from Wales and we will want to acknowledge real progress where that has been made. I am not competitive, but we do seem to be doing slightly better than the NHS in England in our response, which is pleasing to me as a representative of DRC Wales. However, there are gaps and we are looking for further progress. We hope that the new committee will take an interest in that. I recognise that you cannot commit them to doing that and we will bring matters to its attention when the inquiry panel has reconvened and submitted its report.

[240] **Rhodri Glyn Thomas:** We will include that in the legacy report of the committee, which will be passed to the committee that takes over responsibilities after 3 May. It is an issue that we have taken a great deal of interest in and your comments are encouraging in terms of the steps that have already been taken.

[241] Shall I ask the Minister to respond to your comments before calling the other members of the commission?

[242] **Brian Gibbons:** I think that it would be better for Sarah, Phil, or maybe Ann to deal with some of those points.

[243] **Rhodri Glyn Thomas:** Anyone but you, Minister. [*Laughter.*]

[244] **Brian Gibbons:** That sounds good to me.

[245] The finding relating to bowel cancer is fairly novel. Before we go too far, I think that it was noted in the original report that this needed further research and so on to confirm its validity. We have referred this to the cancer networks and have asked them to take a further look at it. We have to ensure that further research is done. This is an example where qualitative research has thrown up this finding. Whether it is a chance finding or there is something substantial behind it, we may need wider epidemiological studies and so on for clarity. I do not know whether you have done any further research or a literature review or whatever; I have not.

[246] **Ms Jerram:** We went back to our researchers following the last committee meeting. I am not a researcher or a member of the medical profession. I asked the researchers who organised the research whether the Government should act on this and whether the information was good enough for a Government to act upon. We were reassured that the researchers who undertook this piece of work are the researchers used by the Department of Health and are very highly regarded, and I was told that if qualified researchers in the Assembly Government were to look at the whole piece of work, they should be impressed by its quality and by the level, depth and quantity of data. We believe that it is the biggest survey ever done in the English-speaking world—according to the list of reviews that have been done—on data taken from patient records. Therefore, we feel that it is a significant piece of work. I passed over to Peter Martin, who was involved in putting this together, the contact details for the doctor concerned. I understand that she is willing to take questions from the Government, and would be happy to answer those, and to perhaps try to interpret this in a policy sense for you. It is probably better that you talk directly to her, rather than through us, not wanting in any way to cloud things.

[247] **Brian Gibbons:** Because you have this new finding, did you trawl back—not you, personally—through the medical literature, to see whether this message was out there, and, because no-one was really looking for it, had the light not gone on in people's heads? Sometimes, when you go back through other studies, and so on, you say, 'Oh yes, the message is there, but we did not think that it was biologically plausible, or whatever the reason was; we just thought that that was a chance finding'. There may be signals in other literature, and I do not know whether that exercise has been done to see whether this message has been coming from other research, but, because people did not think that it was likely to be relevant, they just passed over it.

[248] **Ms Jerram:** We will certainly look into that. However, one issue is that this is a brand-new international finding.

[249] **Brian Gibbons:** Yes, that is the point.

[250] **Ms Jerram:** Therefore, it is difficult, is it not, and we appreciate that. However, we will look into a literature review.

[251] **Brian Gibbons:** Some of my colleagues may wish to comment. [*Laughter*.]

[252] **Rhodri Glyn Thomas:** Will Sarah respond, first, to some of Will's points?

[253] **Dr Watkins:** To reassure Laura, and the DRC, our response states that,

[254] 'the Assembly Government will encourage services to continue pursuing the health

equalities agenda and to continue to meet statutory responsibilities'.

[255] That means that the Office of the Chief Medical Officer will also use this data and the literature when it considers its health promotion strategies. There is a broad number of recommendations, and there are many areas where you want us to take your findings into account, and we will. Therefore, in some ways, again, we can probably tweak that particular bit before it goes onto the website as well, and we will use your work when we develop our health promotion strategies, which I believe is what you are looking for.

[256] **Mr Chick:** On bowel cancer, I have raised this with the cancer network lead. However, I add the caveat that we are waiting for the peer review, but, from what you have said today, we will need to follow that up now. The network was extremely interested in the finding, and I said that, subject to the peer review coming through, we would raise it with it again. Therefore, I will take that back, and we will look at the issues that you have raised about the status of the research.

[257] **Ms Lloyd:** Perhaps I should answer the question on best practice.

[258] **Rhodri Glyn Thomas:** You may as well join in. [*Laughter*.]

[259] **Ms Lloyd:** Yes, as I am here. [*Laughter*.]

[260] As you know, what the National Leadership and Innovation Agency for Healthcare has done is draw together best practice, and ensure that it is spread out in the NHS. We have also just established the Social Services Improvement Agency, which will largely deliver the same for social services. However, your fears about whether people pick up best practice are shared. Therefore, starting this past year—and we have just had its first results—I asked that, on behalf of the Minister, a modernisation audit be undertaken by NLIAH, to see where each organisation in the NHS in Wales was in picking up and addressing best practice, and why they had not put the best practice guidelines in place, or whether they had something better to offer. Therefore, we now have a baseline, and the regional offices are working with all organisations to ensure that they have good plans for putting best practice in place, or for sharing additional work that they have done. That forces the pace for them.

[261] **Rhodri Glyn Thomas:** Laura or David, do you wish to raise any issues?

12.20 p.m.

[262] **Ms Jerram:** On that point, that is very reassuring. One thing that we are striving to achieve is ensuring that small organisations, which are working hard on the ground, and which sometimes do good things on pilot budgets and small resources, know where to go to get advice on how to turn local success into something national, or how to influence national policy, and we were wondering whether some kind of website where you could log on, record what you are doing and find out how to evaluate your project, how to organise a conference and where to get funding for good ideas, would enable people to see that there are clear, transparent pathways for going from something small to something big and that it is not an ad hoc, you-are-lucky-if-you-get-there kind of experience. We have a whole list of small projects that we would be happy to talk to about such an initiative. That would be great.

[263] **Rhodri Glyn Thomas:** I think that you are getting a very positive response from officials.

[264] **Mr Groves:** I would like to reiterate a couple of Will's points on recommendation 6 in terms of access to healthy eating and healthy living for people in institutional settings and the need for an overarching mechanism or some sort of framework to enable a refocusing at a

national policy level towards health with regard to people with learning disabilities, because the principles and responses document was primarily focused on social services.

[265] We were pleased with the commitments in the document to the health and social care wellbeing strategy's guidance to the refocusing around disabled people, including people with learning disabilities and mental health problems. I also commend our consultation response to that, if I may.

[266] **Rhodri Glyn Thomas:** This process has been productive in terms of the Government's response being presented to us in the committee and having the opportunity to have the Disability Rights Commission with us to look through that. So, we look forward to further progress in this matter.

[267] Diolch yn fawr iawn ichi. Dyna ddiwedd y cyfarfod. Thank you very much. That is the end of the meeting.

Daeth y cyfarfod i ben am 12.22 p.m.
The meeting ended at 12.22 p.m.