Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

The National Assembly for Wales
The Health and Social Services Committee

Dydd Mercher, 23 Tachwedd 2005
Wednesday, 23 November 2005

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 o'r Cynulliad yn bresennol: David Melding (Cadeirydd), Jocelyn Davies, Brian Gibbons (y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol), John Griffiths, Val Lloyd, Lynne Neagle, Jonathan Morgan, Jenny Randerson, Karen Sinclair, Rhodri Glyn Thomas.

Swyddogion yn bresennol: Janet Attwell-Thomas, Uned Cynorthwyo a Datblygu Llywodraethu Clinigol; Stephen Boyce, Gwasanaeth Ymchwil yr Aelodau; Anna Daniel, Gwasanaeth Ymchwil yr Aelodau, Swyddfa Brwsel; Ann Lloyd, Pennaeth yr Adran Iechyd a Gofal Cymdeithasol; Andrew Powell-Chandler, Gwasanaethau Deintyddol Cyffredinol a Gwasanaethau Optometrig; David Salter, Prif Swyddog Meddygol Dros Dro.

Gwasanaeth Pwyllgor: Jane Westlake, Clerc; Claire Morris, Dirprwy Glerc.

Assembly Members in attendance: David Melding (Chair), Jocelyn Davies, Brian Gibbons (the Minister for Health and Social Services), John Griffiths, Val Lloyd, Lynne Neagle, Jonathan Morgan, Jenny Randerson, Karen Sinclair, Rhodri Glyn Thomas.

Officials in attendance: Janet Attwell-Thomas, Clinical Governance Support and Development Unit; Stephen Boyce, Members' Research Service; Anna Daniel, Members' Research Service, Brussels Office; Ann Lloyd, Head of the Health and Social Care Department; Andrew Powell-Chandler, General Dental Services and Optometric Services; David Salter, Acting Chief Medical Officer.

Committee Service: Jane Westlake, Clerk; Claire Morris, Deputy Clerk.

Dechreuodd y cyfarfod am 9 a.m.
The meeting began at 9 a.m.

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

David Melding: Good morning ladies and gentlemen, and welcome to this meeting of the Health and Social Services Committee. I remind people that these proceedings will be conducted in Welsh and English. When Welsh is spoken, a translation will be available through the headsets. The headsets will also amplify our proceedings, so those who are hard of hearing can use them. If you have any difficulty in operating them, please indicate to the usher, who will help you. Please switch off all electronic equipment, including mobile phones, pagers and BlackBerrys. Even in silent mode, they interfere with the recording equipment. In the unlikely event that it is necessary to evacuate this room, please exit, turn left and follow the usher, who will lead us out to safety.

There are no apologies, but I understand that Lynne Neagle will be slightly delayed. I invite declarations of interest. I see that there are none.

9.01 a.m.

Rhestr o Is-ddeddfwriaeth Arfaethedig
Schedule of Proposed Secondary Legislation

David Melding: As is our practice, we will look at the additions to the list and then identify possible pieces of legislation for full scrutiny. I will take the subordinate legislation in the health and social care portfolio first. That appears on pages 16 to 19. Do any Members want to call any items in?

Karen Sinclair: I would like to look at HSS 36(03), which is the National Health Service (Pharmaceutical Service) (Wales) Regulations 2005, along with HSS 38(03).

David Melding: What page is that?

Karen Sinclair: It is page 3.

David Melding: We are on page 16.

Karen Sinclair: I am too early, David. I am sorry.

Jonathan Morgan: I would like to look at HSS 32(05), which is on the 'PDS Statement of Financial Entitlement: Directions'.

Jocelyn Davies: Could we look at HSS 38(05) on the next page?

David Melding: HSS 38(05) is on amendment directions to local health boards and NHS trusts.

The Minister for Health and Social Services (Brian Gibbons): Do you want me to say something on that?

David Melding: I do not think so. We are just saying that we may want an extended procedure on these items, and we will certainly call them in.

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Jocelyn Davies: Has not HSS 39(05), on the commencement Order No. 5, already gone through? It is added here as a new item.

David Melding: Yes, it has. It was subject to a letter, I think, from the Minister. I made the point in Business Committee.

Jocelyn Davies: It is worth raising it for the record here.

Brian Gibbons: It is just to give us extra flexibility to recompense people who sit on the panels.

Jocelyn Davies: That was not the point, really. It was listed here as a new item when it has already gone through, although I do not believe that we would have any problem agreeing with this.

Brian Gibbons: No. It is pretty minor.

Jenny Randerson: On page 16 and at the top of 17, there are things relating to dentists, which I know that we are discussing today. However, I want to put down a marker that we will need to have them come back when it is agreed, under the arrangements that we agreed with the Minister, as being the best possible thing that could be done.

David Melding: The agreement is that we look at the drafts this morning and that we would be informed about any substantial change in terms of that draft. We may then need to look at that, but I suspect that it is unlikely that there will be a substantive change in the regulations. However, if there is, the Minister has already said that he will come back.

Jenny Randerson: At the beginning of the pages, which I know that we do not look back at, there are many things connected with pharmacy and pharmacists and I do not see

consolidated regulations, which we were expecting. They were due out in the autumn but, clearly, autumn has passed and they do not appear to be down here as new items. So I am just checking up on where we are on them.

David Melding: Minister, can you give us an update?

Brian Gibbons: We are still looking at bringing them forward; it will possibly be even as late as Easter, but there is work ongoing. We had a meeting with Community Pharmacy Wales about two or three weeks ago on some of the issues around that as well. From what the officials explained at that meeting, we are certainly still two or three months away from completing those consolidated regulations.

David Melding: Okay, but you have obviously heard that the committee is likely to be interested in those consolidated regulations when they appear.

Rhodri Glyn Thomas: Hoffwn ddod yn ôl am eiliad at y rheoliadau sy'n ymwneud â fferyllwyr a fferyllfeydd. Hyd y cofiaf, bu ichi ddweud y byddai modd dod â'r rheoliadau gyda'i gilydd atom ni yn yr hydref. Dywedwch yn awr fod hynny'n symud ymlaen i'r Pasg. Beth sydd wedi achosi'r oedi, oherwydd, y tro diwethaf y bu ichi sôn amdanynt, yr oeddech yn hyderus iawn y byddai modd eu cyflwyno ger ein bron yn yr hydref?

Rhodri Glyn Thomas: I wish to come back for a second to the regulations regarding pharmacists and pharmacies. My recollection is that you said that you could bring those regulations together before us in the autumn. Now you are saying that that will move on to Easter. What has caused the delay, because the last time you talked about them, you were very confident that it would be possible to present them to us in the autumn?

Brian Gibbons: I think that it really is just an issue of capacity and the fact that a lot of the regulations are being brought together. A lot of the pharmacy regulations, particularly the agreement, were basically the English regulations that were slightly tweaked in the Welsh context. A lot of the consolidated regulations are dealing with issues on which we are taking a somewhat different line to that in England. So, officials are having to deal with that, as well as other things in relation to implementing the pharmacy contract. I think that it is a capacity issue as much as anything else.

David Melding: I think that the committee will get sore if it does not have a chance to apply the extended procedure to these regulations and they come through at the last minute before their application on 1 April. If that is avoided, then I think we can live with the delay, but that is the issue.

Brian Gibbons: In fairness to Community Pharmacy Wales, it would have liked to have seen these regulations now rather than having to wait a couple of months. However, it did understand that there are capacity issues and that, if we had more officials available to us to do the work, I am sure that it would be done earlier. However, I do not think that people are going to recommend that.

Jonathan Morgan: First, on the issue of the pharmacy regulations, I have heard what the Minister has said, but he knew that there would be specific regulations that were Welsh; you knew the likelihood of that, Minister. I just think that this smacks of bad planning, quite frankly. I do not think that it sends out the right messages about the seriousness of getting this sorted out, given the disquiet that exists within the pharmacy sector.

Another regulation that I would want us to consider, but for which there is no description of what it is, is the Directions to Local Health Boards as to the Statement of Financial Entitlements 2006. What is that?

David Melding: What is the reference number?

Jonathan Morgan: It is HSS 47(05), which is the last one on page 18.

Brian Gibbons: I think that that represents relatively minor adjustments to take account of the new general medical services contract.

David Melding: We can call it in, even if we do not want to do anything about it ultimately. The Minister may be right and you may agree that it is minor.

Jocelyn Davies: I wish to refer to two items. At the bottom of page 19, there is the Commissioner for Older People in Wales Regulations 2006, which I think the committee would definitely want to consider.

David Melding: Is that HSS 53(05)?

Jocelyn Davies: That is right. The other is on page 18, HSS 44(05), which is the Confidentiality and Disclosure of Information: General Medical Services and Alternative Provider Medical Services (Wales) Directions 2005. We have talked about the confidentiality of patient records in the past, and I think that the committee would like to see these directions.

David Melding: Okay. Are there any further items?

Brian Gibbons: I note that the Commissioner for Older People in Wales Regulations 2006 is due for January 2007, but that is fine.

David Melding: We are giving you advance advance notice.

Jocelyn Davies: If we do not identify them now when they first appear on the list, and we try to identify them later, the Chair will say 'no'.

David Melding: Or at least will get grumpy; I would.

The second list relates to the Food Standards Agency, and the additions appear on pages 26 and 27. Are there any items for extended scrutiny?

Jenny Randerson: On the Food Additives Regulations Wales, FSA 29(05), there is a great deal of public interest in that and we should look at that.

David Melding: Okay, FSA 29(05) has been identified. Anything else? I see that there is not.

9.10 a.m.

Materion Ewropeaidd Cyfredol
Current European Issues

David Melding: We now move to item 3 on current European issues and I welcome Anna Daniel from the Members' Research Service in Brussels. A very helpful paper has been prepared, which brings us up to date with issues on which we have expressed an interest. We have had an update on most of them. Anna will give us an oral update in addition to what we have in our paper, so before I ask committee members to express their views, if you wish to update us on anything, please do so now, Anna.

Ms Daniel: I will send a note to Members later on the update on the EU paediatrics

regulation. The first reading of that has gone through the European Parliament, but it will be a while before an agreement is reached on that.

Yr oeddwn eisiau tynnu sylw'r Pwyllgor yn benodol at y Papur Gwyrdd ar sefydlu strategaeth iechyd meddwl ar gyfer yr Undeb Ewropeaidd. Mae hwn yn flaenoriaeth gan y Comisiynydd Iechyd, Markos Kyprianou, ac y mae Stephen Boyce am roi crynodeb bach o brif bwyntiau'r papur i chi i'w hystyried os ydych am roi ymateb i'r Papur Gwyrdd.

I wanted to draw the committee's attention specifically to the Green Paper on establishing a mental health strategy for the European Union. This is a priority for the Health Commissioner, Markos Kyprianou, and Stephen Boyce wishes to outline the main points of that paper for you to consider if you want to respond to the Green Paper.

David Melding: Everyone will have read the paper, Stephen, which I thought was very interesting, but you may just want to elaborate.

Mr Boyce: I will just comment briefly. If you have read the paper, then you will know that this is a proposal for a Green Paper on mental health by the European Union to which it is inviting comments by 31 May next year, so there is quite a long period in which to respond to it. The EU wants to know people's views on whether one is needed at all and, if so, what it should contain. Some of the suggested content of an EU mental health strategy would be to promote better mental health among EU states, protect the rights and dignity of people with mental health problems and an information exchange on policy, practice and statistics between EU states. This is seen in the context of the EU's work on promoting economic wellbeing, solidarity, prosperity and social justice. So they see this in the broad context of the work of the EU and there is work to be done to equalise some of the mental health practices among EU states, because there is a wide variety in levels of spending and other indicators such as suicide rates and depression, use of compulsory admissions and those kinds of things. So, the idea is to address some of those issues.

David Melding: Before I call Members to respond, the committee has done a lot of work on mental health issues, and much of that could probably be summarised for a submission. The committee may look to do half a committee session and possibly even invite a couple of witnesses along. However, in general, the focus on stigma, attitude and non-legislative approaches would seem to accord with quite a lot of the salient issues that we have identified.

Rhodri Glyn Thomas: Dyna'r union bwynt yr oeddwn am ei godi. Gwnaethom dipyn o waith ar y pwnc hwn yng Nghymru a byddai'n dda pe baem yn gallu crynhoi hynny a nodi rhai o'r pwyntiau yn ein gwaith. Credaf fod mater y stigma yn eithriadol o bwysig, gan fod y Papur Gwyrdd yn edrych ar hawliau, urddas a chynhwysiad cymdeithasol pobl sy'n dioddef o broblemau iechyd meddwl. Yr ydym wedi derbyn llawer o dystiolaeth ac wedi gwneud llawer o waith yn benodol ar hynny, a byddai'n gyfle i gael mewnbwn i'r papur. Yr wyf yn cefnogi yn llwyr eich awgrym. A yw'n bosibl trefnu, drwy'r ysgrifenyddiaeth, inni gael copi o'r Papur Gwyrdd?

Rhodri Glyn Thomas: That is exactly the point that I wanted to raise. We have undertaken quite a lot of work on this matter in Wales and it would be good if we could summarise that and note some of the points in our work. I think that the issue of stigma is exceptionally important, as the Green Paper looks at the rights, dignity and social inclusion of people who suffer from mental health problems. We have received a lot of evidence and have undertaken a lot of work specifically on that, and it would give us an opportunity to have some input into the paper. I totally support your suggestion. Would it be possible to arrange, through the secretariat, for us to receive a copy of the Green Paper?

David Melding: Yes. Has the Green Paper been issued yet?

Ms Daniel: Yes, it has.

David Melding: So, there is probably a web-link that can be circulated. That is important. Are there any more questions on the mental health issue? I think that everyone agrees that the committee should prepare a submission by 31 May, but we would probably want to do it earlier than that. That is useful. Are there any comments on the other general areas on which we have been updated, namely avian influenza, the working time directive, and the services directive?

Jenny Randerson: There is a suggestion in annex A that we need to monitor the influenza pandemic preparedness policy. I do not know whether that is an either/or with the avian influenza directive, but we should monitor the influenza preparedness.

David Melding: I am sure that the Minister would be happy to bring that before committee. Informal briefing sessions have been offered.

Brian Gibbons: Can I clarify what you would like, Chair? We are working to a number of documents, both on the commissioning side and the resilience fora, on our response to a major infectious disease as well as to the implementation of the wider UK guidance on responding to avian flu? Would you like a response to all of those things?

David Melding: If you look at annex A, particularly the fourth paragraph, it outlines some of the actions that, on the European level, are thought to be appropriate for the nation states to be taking.

Jenny Randerson: The second paragraph sets out what the European Commission is co-ordinating. That is what I had in mind.

David Melding: I do not see any problems. Would you like to prepare a paper and come back?

Brian Gibbons: There may be some slight practical problems, because I do not think that it matters that the EU is of a unified mind on some of these issues—I know that it is not in this paper, but I know from other documents that the EU is working towards a consensus, or a united position, on a number of these issues. I do not think that there would be a well-defined consensus in some areas on what the European-wide action would be.

David Melding: I think that what has been suggested is that we link our actions and preparations to the European agenda. Most would agree that the locus remains pretty much with the nation state, but there are some points that also have a European dimension. I am slightly surprised that we have a difficulty here, frankly. I thought that it would be quite easy for the committee to do a bit of work on this.

Brian Gibbons: It is just that there is a lot going on at a number of different levels in doing this. It would be quite possible to bring in a wheelbarrow-full of stuff and present it to the committee. If that is what the committee wants, then we can do that, but we could bury ourselves in this. I wanted to narrow down what Jenny was asking for. In principle, there is no problem.

David Melding: I am sure that you would find that a number of salient points would emerge from any morass of material that you dump on us. There are some pretty obvious issues of public concern.

Brian Gibbons: Do you want that proofed against what goes on at a European level? That would be the point of departure.

9.20 a.m.

David Melding: As I have just explained, Brian, I think that it would be useful for the committee to look at the issue of how we are preparing for the likelihood of a pandemic and how those preparations also link into European policy on co-ordinating certain issues.

Brian Gibbons: So it is about what is going on in Europe; okay.

David Melding: It would give us an opportunity to look at the issues of developing a vaccine, the anti-viral stocks, and what will happen to primary healthcare if there is a sudden surge of demand. These have been subject to informal briefings, so the information is clearly there and I would say that it is fairly focused.

Brian Gibbons: There are documents.

David Melding: I do not think that there is a great issue about whether the Government is way out of sync with what Europe is saying. As you have said, there are different levels of competence and we would take the opportunity to reflect on what is also done at a European level while looking at preparations in the UK, particularly in Wales. Jenny, did you want to add anything?

Jenny Randerson: I just wanted to express my surprise that the Minister has a problem with giving us an update on preparations in the light of the European context. We are not asking for tomes of technical instruction; we are asking for a paper which refers to what has happened at a European level and how Britain's actions fit in with them. If Britain is going in a different direction, it would be useful to know why.

Brian Gibbons: Would it be better to do a paper on what we are doing and cross-reference that to the European equivalent?

Jenny Randerson: Yes; that is fine.

David Melding: That is precisely what we need.

Brian Gibbons: That is what we will do.

David Melding: I think that we got there in the end. Are there any other issues, or are you happy with the updates on the working directive and the services directive?

Jonathan Morgan: In respect of the services directive, which I note is scheduled for a Plenary vote in January, assuming that the compromises are reached, the amendments are sorted out, and it actually goes through next year, what is the likely timescale for implementation?

Ms Daniel: The council also has to come to an agreement with the European Parliament, so the UK presidency is hoping to reach an agreement possibly before the end of the year on a common position. The European Parliament will then give its First Reading before the council formally adopts a position, then it goes back to Parliament for the Second Reading. There will still be quite a few long months ahead before the final decision is taken on the various clauses of the directive.

Jonathan Morgan: Okay.

David Melding: I think that that is it. Thank you for that useful update. Given the committee's work and interests, it is of particular value to have someone to advise us on

issues of specific concern to us. Mental health and avian flu, to a lesser extent, I suppose, are issues that we have looked at quite extensively. Thank you for that. I am sure that the committee will value your occasional contributions every six months or so.

9.23 a.m.

Datganiad Cyllideb
Budget Statement

David Melding: The Minister will give an update, but I do not think that we are quite where we expected to be, given that the situation in relation to the draft budget has been slightly irregular this time.

Brian Gibbons: Since the Finance Minister issued her written statement, in which she suggested that she would return with the draft budget before 15 November, the position has moved on. Discussions continue between the Finance Minister and finance spokespeople for other political parties. The First Minister has held a series of meetings with party leaders on the budget, the latest of which took place last night. All of this means that consideration of budget issues continues. We have not reached a position whereby a further revised budget can be produced. We have set out our budget priorities, having listened to the committee. It remains a concern that health is not featured on the various lists for modification of the budget programme. While money itself is not the answer, adequate resources to deliver 'Designed for Life', contractual change and other important challenges facing health and social care, are important.

David Melding: Thank you, Minister. That is where we are. There is some dispute as to whether they met last night, but that is not a substantial matter of concern to us. They will meet soon, presumably. We are in a situation of some uncertainty, so we cannot really deal with this item substantively. However, if Members want to make brief remarks, I will humour them.

Rhodri Glyn Thomas: Mae gennyf gwestiwn penodol, nad yw wedi codi yn y gorffennol, hyd y cofiaf. Gyda'r gostyngiadau a'r bwriad yn y pen draw i gael gwared ar ffioedd presgripsiwn, a yw'r Llywodraeth yn gwneud unrhyw fath o astudiaeth i weld a fydd cynnydd yn y galw am feddyginiaeth gan y bydd ar gael yn rhad ac am ddim? Ynteu a ydych yn rhagdybio y bydd y sefyllfa yn aros fel ag y mae o ran y galw? Os bydd cynnydd yn y galw, mae gan hynny oblygiadau i'r gyllideb.

Rhodri Glyn Thomas: I have a specific question, which I cannot recall being asked in the past. With the reductions and the intention, ultimately, to get rid of prescription charges, is the Government undertaking any sort of study to see whether there will be an increase in the demand for medication because it will be available free of charge? Or do you foresee that the situation will remain the same? If there is an increase in demand, there will be implications for the budget.

Brian Gibbons: I do not think that any formal studies will be done on that. There are trends to increase the level of prescribing, but I do not think that we have specifically factored in the effect of free prescriptions, have we?

Ms Lloyd: We did some brief calculations when we had been building up the budget over the last few years. We anticipate that the number of free prescriptions will rise, and that has been built into the assumptions. There is very little evidence on which we can build any assumptions. However, we will undertake a clear tracking of those assumptions against the trends that are now coming out, year on year, with the reduction in the price of prescriptions, given the health needs, of course.

Rhodri Glyn Thomas: Os nad oes llawer o dystiolaeth i chi seilio eich rhagdybiaethau arni, ymddengys fod hynny'n ddadl gref dros gael astudiaeth fanwl i weld beth fydd y sefyllfa debygol. Yn ôl yr hyn yr ydych newydd ei ddweud, nid yw'ch rhagdybiaethau wedi eu seilio ar dystiolaeth, felly, ar y gorau, rhyw amcan ydyw o beth y tybiwch allai'r sefyllfa fod. Gallai fod yn dra gwahanol i'r hyn yr ydych yn ei ragweld. Byddwn yn pwyso arnoch, felly, i o leiaf ystyried cael astudiaeth fanwl.

Rhodri Glyn Thomas: If there is not much evidence on which you can base your presumptions, that would seem to be a strong argument for having a detailed study to see what the likely situation would be. From what you have just said, your presumptions are not based on evidence, so, at best, they provide a rough idea of what you presume the situation could be. It could be very different to what you foresee. Therefore, I would press you to at least consider conducting a detailed study.

Brian Gibbons: The evidence from monitoring the prescriptions to date is that there has not been any substantial change. Therefore, if we are to model on what has happened already, while there has been a fairly significant increase in the prescribing budget, we have not been able to discern an effect of the reduced cost of prescriptions. However, as Ann said, we are continuing to monitor it, but, insofar as we have monitored it and can determine any trend, there has not been any significant change.

David Melding: Jenny, did you want to ask a question?

Jenny Randerson: It was on exactly the same topic, so it has been answered, thank you.

David Melding: Okay. I do not see any other points for scrutiny at this stage. When the final budget is published, or the next draft version—however the procedure will be undertaken—the committee will look at that with interest.

9.28 a.m.

Rheoliadau'r Gwasanaeth Iechyd Gwladol (Contractau Gwasanaethau Deintyddol Cyffredinol) (Cymru) 2006, Rheoliadau'r Gwasanaeth Iechyd Gwladol (Cytundebau Gwasanaethau Deintyddol Personol) (Cymru), Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Deintyddol) (Cymru) 2006 The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006, The National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006, The National Health Service (Dental Charges) (Wales) Regulations 2006

David Melding: We have these regulations in draft, but, I am assured, near-final, form. Given the time constraints that have been imposed on us, it is only now that we will have a chance to look at them in detail in this state. However, as he indicated earlier, the Minister has agreed that, should these draft regulations change substantially, the item will come back to us for a further view.

That said, we have had two amendments, and 11 points of clarification. A few Members have asked me whether, if there is time—and there is likely to be time because of other items now being shorter than anticipated—some general points of inquiry can be raised on dentistry. However, the Minister may not have the detail to hand to answer immediately and, if that is the case, he will have to respond in writing, but it would be quite useful to use the session, if possible, to look at some of the wider issues around dentistry. What I intend to do, therefore, is deal with the amendments first, and then we can work through the points of clarification. Depending on how long it takes us to deal with the amendments, we might break after that and come back after tea and coffee to deal with the points of clarification and any wider

discussion. We will start with Jenny Randerson.

9.30a.m.

Brian Gibbons: May I just come in on that?

David Melding: Do you want to make a few introductory remarks, Minister? I beg your pardon; I was a bit pre-emptive there.

Brian Gibbons: These regulations introduce reform to NHS dentistry and form part of the overall strategy that is designed to promote a dental service that is clinically effective and encourages best practice, improve the quality of dentists' working lives, improve access to service for patients, move away from the item of service, and encourage fewer interventions, thereby freeing up time for more preventive work. The GDS and PDS regulations describe the terms and conditions of the new dental contracts, and set out a range of services to be provided. The dental charges regulations provide for the making and recovery of charges for the provision of dental treatment. The move to local commissioning of NHS primary care dental services offers a fresh start for dentists and patients. These reforms place dentistry more firmly in the mainstream of the NHS, with easier access to service, providing appropriate clinical care, and giving out key public health messages to encourage self-care wherever possible. For dentists, the reform will move towards a guaranteed income, scope to plan services and enter the fee-per-item treadmill, and, for patients, the range of treatments provided by the NHS will be clearer. Dentists will still be able to offer NHS and private dental care and continue to see their existing patients, and this applies whether or not the existing patients are children or exempt adults.

Over time, patients should receive a more appropriate level of service, as the local NHS more closely aligns resources for dentistry with identified local need, and commissions services accordingly. The local commissioning system means that if a dentist leaves the practice, resources for his or her contract will revert to the local health board. Therefore, the level of resources for NHS dentistry at a local level will remain constant and not be affected by the decision of an individual dentist. Local health boards' new responsibility for local dental services will allow them to commission services to meet particular local oral health needs. The Assembly Government has engaged in an open way with the dental profession in Wales, and we have been able to use the opportunity of devolution to introduce a number of Welsh-specific variations, which we hope will address specific dental concerns, for example, by reducing the units of dental activity requirement by 10 per cent and by increasing the monitoring tolerance to 5 per cent. We have also recognised concerns in relation to the estates of deceased dentists, as well as repeating the assurances given by the UK Government in terms of the age composition of dentist lists and the ability of dentists to mix their practice in line with informed patient choice and clinical necessity.

In stating the flexible approach that the Welsh Assembly Government has adapted, we have also sought to communicate this to dentists across Wales, so that they are fully up-to-date on what the new dental contract in Wales means, rather than looking merely at what is going on at a wider UK level. We have also indicated to the British Dental Association that we are keen to continue our dialogue with it to ensure that people have improved, real access to NHS dentistry here in Wales should they wish to use it.

David Melding: Thank you, Minister. I apologise; I thought the amendments related to the same regulations, but they do not. We will take the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 first. We have one amendment from Jenny Randerson, and then a point of clarification, also from Jenny. After that, we will have a short break for tea and coffee, and then we will come back and deal with the National Health Service (Dental Charges) (Wales) Regulations 2006. I apologise for that slight confusion. As

we are ahead of our agenda, we will wait for our legal adviser to join us. He is not here because this item was scheduled for later in our proceedings. We will take a short break while Peter runs down the corridor to get here.

Gohiriwyd y cyfarfod rhwng 9.35 a.m. a 9.37 a.m.
The meeting adjourned between 9.35 a.m. and 9.37 a.m.

David Melding: Welcome, Peter; our agenda has been quite disrupted, and it is not your fault. We are now in a position to scrutinise the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006, and we will look at the amendment first.

Jenny Randerson: I propose the following amendment to the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006. In Schedule 3, Part 1, paragraph (4)(a), delete 'age' and add new paragraph (b):

'a person's age, except in that it is permissible to give preference to the treatment of those under the age of 18'; and

amend paragraph (b) as (c).

Briefly, it is a great pity that this contract differs so little from that of England. Although there are some good things in it, there is an awful lot that is apparently driving dentists from the NHS rather than attracting them into it. One of the things that I have discovered from doing a survey of all dental practices in Wales is that a large number of NHS dentists currently only take on NHS patients who are either children or benefit claimants. I do not think that that is a desirable situation at all but, given that there are few NHS dentists, and that, for example, only four NHS practices outside south-east Wales are currently taking on new patients, my amendment is intended to enable dentists to discriminate in favour of children, or, in other words, to ration out their services to give preference to children.

It is a sad state of affairs that I have had to put in an amendment that allows that discrimination, because everyone should have the right to NHS dentistry. However, this is a recognition of the scarcity of the service. Currently, the contract does not allow dentists to discriminate between different types of people when they apply to be on their lists. That means that they cannot pick and choose in any way, though they currently do pick and choose, and they are worried that they will not be able, specifically, to discriminate in favour of children and benefit claimants.

9.40 a.m.

I confess that I did not include benefit claimants in the amendment, because, when I looked at the legal aspects of it, I realised that it would be so complex that, as a simple backbencher amendment, it would not be manageable. However, I think that we should be considering children specifically in this regard, because healthy teeth, good hygiene practices and dental care for young people create new generations of people with good teeth.

David Melding: I will let the Minister respond, and, if other Members wish to make short contributions, I will take those.

Brian Gibbons: This area has been a source of aggravation and, I have to say, confusion. Certainly, the British Dental Association took the view that the new contract proposes restrictions on the way in which people accept patients to their lists, and they have been reassured that that is not the case. In some of the guidance and explanatory material that we have sent out to dentists, we have sought to make that clear. Also, one of the advantages of the new set of arrangements, which I specifically mentioned in my introductory remarks, is

that, in commissioning certain services, local health boards will identify priority groups for services commissioning. Clearly, for many of the reasons that Jenny gave, one of the priority groups for commissioning will be dental health services for children. I think that the point that Jenny is trying to make is covered in the contract as we speak, and it will be part of the commissioning process for local health boards, which is at the core of this contract. We would be concerned that the form of words could create the very difficulty that Jenny is trying to address, in that people might wish to challenge it by putting in this form of words and say that this is bringing an element of discrimination into the contract that we would not want to see there. However, the purpose of the amendment can be addressed in the present situation, because some of the misunderstanding is not correct, and the commissioning will allow local health boards to commission services precisely for young children if that is a priority.

David Melding: We can now have a short debate on the merits of the amendment.

Jonathan Morgan: The Minister said that what Jenny was trying to ensure is already provided in the contract. Can you point me to the specific part of the regulations that allow that, Minister?

Brian Gibbons: It is part of the local health board commissioning process and the ability of local health boards to commission services for specific groups within their populations. So, it is intrinsic to the whole switch from the present contract to an LHB commissioning model, and that is precisely one of the qualitative changes that have taken place in the contractual arrangement.

David Melding: It could be a personal dental service—is that what you are saying?

Brian Gibbons: No. It can be done under even under the new general dental service. The local health board, as part of the commissioning process, will have to look at the range of dental provision in its locality, and, for example, it may decide that a key priority, if there is a low level of NHS access, is access for everybody. Equally, it might look at the profiling of dental care and decide that adults are finding it easy to access and that children are not, and then the commissioning process would be able to pick that up and make specific arrangements with individual dental practices to deliver precisely what Jenny is asking for. So, that is absolutely intrinsic to the whole shift to this new contract.

Jonathan Morgan: In essence, then, it would be for the local health board to determine what it wanted to commission.

Brian Gibbons: Sure.

Jonathan Morgan: So, you would have a postcode lottery whereby, perhaps, one local health board would follow what Jenny is, in essence, suggesting, while another local health board perhaps would not. Where is the safeguard? You said that what Jenny is proposing is already covered in the contract. Her proposal is, in essence, an all-Wales safeguard. You do not have that if you are merely allowing the local health boards to make a local decision, and that is part of the concern. Can you expand on that, Minister?

Brian Gibbons: If you are saying that local health boards are so perverse or incompetent in the way that they do business that—and it is difficult to understand why any local health board would take this view—they would not commission dental services on the basis of local priority, children being an obvious key priority group within that, then what you are saying is conceivably possible. However, it seems to be taking the most perverse and illogical position to commissioning to suggest that that would happen, and one would wonder about the competence of a local health board if that was the way that it decided to commission dental services. It is just like saying that general medical services would not commission cardiac

prevention programmes. That is theoretically possible, but it is hardly conceivable.

Jonathan Morgan: So, why not provide the safeguard?

David Melding: I think that the positions are clearly established.

Rhodri Glyn Thomas: Ni allaf ddeall gwrthwynebiad y Gweinidog i'r gwelliant hwn. Mae'n dweud bod ganddo bryder y byddai geiriad y gwelliant yn creu sefyllfa lle y gallai pobl ei herio ar sail camwahaniaethu. Byddwn yn falch o gael y farn gyfreithiol ar hynny oherwydd, os dyna sail y gwrthwynebiad, byddwn yn meddwl y byddai pobl yn gallu—

Rhodri Glyn Thomas: I cannot understand the Minister's opposition to this amendment. He says that he is concerned that the amendment's wording would create a situation in which people could challenge him on the basis of discrimination. I would like to hear the legal opinion on that, because if that is the basis of the objection, people could—

Brian Gibbons: No.

Rhodri Glyn Thomas: Dyna'r hyn a ddywedwyd gennych, Weinidog. Dyna oedd eich gwrthwynebiad i'r gwelliant hwn.

Rhodri Glyn Thomas: That is what you said, Minister. That was your objection to this amendment.

O ran yr hyn yr ydych yn ei ddweud ynglŷn â'r byrddau iechyd lleol yn comisiynu, yr oeddech yn cyhuddo Jonathan Morgan o fod yn afresymegol, ond mae eich disgrifiad o'r broses gomisiynu—

Regarding what you say about commissioning by local health boards, you accused Jonathan Morgan of being irrational, but your description of the commissioning process—

Brian Gibbons: No.

Rhodri Glyn Thomas: Dyna'r hyn a ddywedwyd gennych, Weinidog, sef ei fod wedi cymryd agwedd afresymegol at y ffordd y byddai bwrdd iechyd lleol yn comisiynu gwasanaethau. Fodd bynnag, byddwn i'n dweud bod gennych agwedd ddelfrydol tuag at y broses gomisiynu oherwydd ichi ddarlunio sefyllfa lle y byddai'n rhwydd i fwrdd iechyd lleol gomisiynu'r gwasanaethau deintyddol hyn i blant. Nid yw mor rhwydd â hynny oherwydd mae pob bwrdd iechyd yn gorfod penderfynu eu blaenoriaethau ar sail eu cyllideb a'r ddarpariaeth sydd ar gael. Ni allant gomisiynu gwasanaethau nad ydynt yno. Mae'r gwelliant hwn yn gosod yr agenda drwy Gymru gyfan y dylid blaenoriaethu gwasanaethau deintyddol i blant o fewn y gwasanaeth iechyd gwladol. Gofynnaf i'r Gweinidog ailystyried oherwydd bod hyn yn rhoi cyfeiriad pendant i fyrddau iechyd lleol ac mae'n osgoi'r sefyllfa yr oedd Jonathan yn ei disgrifio lle y gallai fod amrywiaeth mawr o ran y ddarpariaeth ledled Cymru a darpariaeth

Rhodri Glyn Thomas: That is what you said, Minister. You said that he had taken an illogical attitude towards the way in which a local health board would commission services. However, I would say that you have taken an idealistic view of the commissioning process, because you were portraying a situation in which it would be easy for a local health board to commission these dentistry services for children. It is not that easy, because every local health board has to decide its priorities on the basis of its budget and the provision that is available. LHBs cannot commission services that are not there. This amendment sets out the agenda throughout Wales that priority should be given to dentistry services for children within the national health service. I ask the Minister to reconsider, because this gives an explicit instruction to local health boards and it avoids the situation, which Jonathan outlined, in which provision could vary across Wales and in which we would have a postcode lottery of provision. I would be glad to hear the legal position on the possibility of this

loteri cod post. Byddwn yn falch o gael y farn gyfreithiol am y posibilrwydd o herio'r gwelliant hwn yn gyfreithiol am ei fod yn camwahaniaethu.

amendment's being legally challenged on the grounds of discrimination.

David Melding: Before I come back to you, Minister, on the general point—

Brian Gibbons: May I just make this point and respond then?

David Melding: I think that we would like to know whether there are likely to be legal problems with the amendment as proposed by Jenny Randerson. Peter, could you give us your view on its technical and legal robustness?

Mr Jones: It refers to Schedule 3, Part I, and I am not sure that it would fit in there. I think that it would be okay in principle, but I think that it would have to be reworded.

Jocelyn Davies: May I come in at this point?

David Melding: I will call you next. I will let the Minister respond, if he wants to, to Rhodri's general views. I think that you have already responded to them earlier, Minister, but you may want to amplify your comments in the light of his remarks.

Brian Gibbons: Our concern, and Peter may wish to respond to this, is that this could be challenged under the Human Rights Act 1998, in that a group of people are getting, if you like, preferential treatment on the basis of age. If Peter's view is that that would not be the case, we would have to take that on board.

9.50 a.m.

Our concern is that precisely what Jenny is trying to achieve may fall foul of the Human Rights Act 1998 because of that. The necessity to run that risk really is not there, because local health boards should be picking up children as part of the commissioning process.

David Melding: That is your view. My attitude is that the committee can propose amendments. They are not mandatory; indeed, they can be overturned in Plenary, by which time, should a specific human rights test need to be applied, it could be done in a robust fashion. It is quite appropriate for the Minister to indicate his views on what is likely to be the case. However, as far as I am concerned, as Chair, the amendment seems to be in order.

Jocelyn Davies: On that point, I listened carefully to what the Minister said, which was that it would be most 'perverse' if children were not prioritised, that, in everyone's view, children should be prioritised, and that, obviously, children would be one of those priority cases. Those are the sort of words that he has used, and it seems to me that the courts would take the same view: that it would be most perverse not to prioritise children. Therefore, a human rights challenge is unlikely to be successful, particularly if the Minister's words are used as the context in which these regulations were passed.

If we think that it is most perverse not to prioritise children, I do not think that we should be too worried about putting that in the regulations. Peter could help us by explaining whether the local health board decision to prioritise children could be challenged in exactly the same way as the legislation.

Mr Jones: It is the same principle.

Jocelyn Davies: It is exactly the same principle. The Minister's defence that the local health

board can prioritise children, so we should not put it in the regulations, is a rather circular argument. I support Jenny's amendment.

Jenny Randerson; I want to ask Peter about the point that Jocelyn just raised. Could the Minister's proposal that the prioritising of children should be done by the LHBs not be challenged under the regulations—the Act as it will be—given that they say that the contractor cannot refuse to provide services on the basis of a person's race, gender, social class, age, religion, sexual orientation and so on? If an LHB prioritises something and the regulations say that you cannot discriminate in favour of one person or another, will there not be a challenge on that?

David Melding: I am not sure that it is fair to put something to Peter, as legal adviser, without notice. I think that the amendment is in order and that we should concentrate on that. Peter, do you want to offer any response?

Mr Jones: On the face of it, I do not think that there are good reasons for refusing the amendment. We will obviously need to look at it again, particularly the human rights aspect of it. However, I am not satisfied that it could be rejected.

David Melding: There are clearly two different approaches to the same common objective, and it will be for the committee to make a decision shortly. I will let the Minister reply, and then, if Jenny wants to push for a vote, I will move to a vote.

Brian Gibbons: You are quite right to say that we have a common aim. That is not an issue. If we can be assured that we do not fall foul of the Human Rights Act 1998, there is no great difficulty with this. The only point I ask Peter to consider is that of the prioritisation of children being done on the basis of commissioning the healthcare needs of children, rather than making a decision purely on age. It is the fact that children have specific health needs that would justify it, rather than the fact that they are children. Lawyers get rich on such arguments, so I am not going to further waste—though 'waste' is not the right word—or prolong the debate. We need legal advice in order to bottom this out. We are working towards a common purpose. With your guidance, Chair, I do not think that there is any point in prolonging the debate.

David Melding: Do you want to proceed with the amendment, Jenny?

Jenny Randerson: Yes.

David Melding: We will therefore move to a vote.

Cynnig: O blaid 5, Ymatal 5, Yn erbyn 0.
Motion: For 5, Abstain 5, Against 0.

Pleidleisiodd yr Aelodau canlynol o blaid:
The following Members voted for:

Davies, Jocelyn
Melding, David
Morgan, Jonathan
Randerson, Jenny
Thomas, Rhodri Glyn

Ymataliodd yr Aelodau canlynol:
The following Members abstained:

Gibbons, Brian

Griffiths, John
Lloyd, Val
Neagle, Lynne
Sinclair, Karen

Derbyniwyd y cynnig.
Motion carried.

David Melding: Still on these National Health Service (General Dental Services Contracts) (Wales) Regulations 2006, there is a point of clarification also by Jenny Randerson.

Jenny Randerson: This relates to units of dental and orthodontic activity, which are defined in great detail in the regulations. Paragraph 14 of the explanatory memorandum refers to the Minister's intention to maintain NHS dentistry services within their current cash limits. Given that there are all sorts of regulations there about practices that fall 5 per cent short of their proposed units of dental activity, can you explain how dentists are allowed to expand and increase their levels of activity? If you are keeping within the current cash limits, they are not allowed to fall below it, so you would expect everyone to go along more or less as they are at the moment. We have a shortage, so how is this going to enable an increase in dental activity?

Brian Gibbons: I accept the point that Jenny is making. Obviously, the current contractual arrangements will continue within the current cash limits. However, one of the big challenges of the new dental contract will be to improve new access and so forth. In the draft budget line, you will see that extra money is being provided for the dental contract so that, as extra access and activity goes on, that will have be to be resourced in addition to the current volume, which is paid for within the existing cash limit. If the contract is going to expand and more people are going to get services, further resources will have to be given to allow that to happen.

Jenny Randerson: One of the problems with dentistry over the past decades, or certainly over the last decade, is that, although there has been a big increase in health service funding in Wales, it has bypassed NHS dentistry. The rest of the health service has had more money, and dentistry has not, in real terms. Unless there is to be a major increase in spending on dentistry, we are not going to solve the problem, are we, Minister?

Brian Gibbons: If I just try to do a rough mental arithmetic calculation, I think that, between 2000 and the end of 2005, spending on dentistry in Wales probably increased by around 20 per cent to 25 per cent. If you look at the draft budget, if we can get it through, you will see that there will be more money for the new dental contract. So, one of the problems that we have, which is one of the inadequacies of the current contract, is that, up to the time of the announcement that I made around two weeks or 10 days ago in committee, when dentists left the NHS, they took the resources out of the NHS with them. That is a problem. However, in terms of the allocation, it went up from around £66.33 million in 2000 to £80 million plus at the end of this financial year.

10.00 a.m.

There has been a significant increase, and further money has been earmarked in the draft budget, but when dentists are leaving, they are taking money with them. However, as I say, hopefully, we have dealt with that issue in the announcement of two weeks ago.

Jenny Randerson: The announcement and the mechanism for the money to stay with the LHBs is a good idea. You point to an increase, but it is not in line with the rest of the health service. We cannot force dentists to stay in the health service. They are contractors; they go where the situation is best, and one of the real concerns is that this unit-of-dental-activity approach is not going to be attractive enough to them to make them stay. You say that there

has been a misunderstanding about this contract, but it is a widespread misunderstanding, in many respects, if it is a misunderstanding.

Brian Gibbons: In fact, if we look at the UDAs in Wales, we have doubled the flexibility that has been offered in England and we have increased the tolerancing. So, we have been pretty flexible and, as I said in my introductory comments, we are having discussions with the British Dental Association, and other dental interest groups, to address concerns where they exist. There is no confusion about the UDA per se, but there may be some confusion in that people do not always realise, if they depend on wider England-Wales sources of information, that we have given a 10 per cent reduction in terms of activity, whereas at a Westminster level, the reduction is only 5 per cent. I think that that is very ambiguous in terms of what we are offering in Wales compared with the wider England-Wales contract.

David Melding: Thank you. I think that both views are now on the record. That concludes scrutiny of the general dental services contracts. I propose to have a break until 10.20 a.m.. When we return, we will scrutinise the NHS Dental Charges (Wales) Regulations 2006.

Gohiriwyd y cyfarfod rhwng 10.02 a.m. a 10.21 p.m..
The meeting adjourned between 10.02 a.m. and 10.21 p.m..

David Melding: Welcome back to the Health and Social Services Committee. I remind everyone to switch off all electronic equipment, mobile telephones, pagers, BlackBerrys and so on. A mobile telephone went off in the first part of the meeting and it causes havoc with our recording. I am not just a mean technophobe—though I am certainly that—as there is a genuine concern. Switch them off; do not leave them on silent.

Rhodri Glyn Thomas: Have you switched off your BlackBerry?

David Melding: I do not have one, so I do not even have to consider the issue.

We continue with our scrutiny of the dental regulations, and look at the National Health Service (Dental Charges) (Wales) Regulations 2006. We have had an amendment to the legislation proposed by Jenny Randerson.

Jenny Randerson: I propose the following amendment to the National Health Service (Dental Charges) (Wales) Regulations 2006: after Schedule 3 insert new Schedule 4 to create a fourth band dedicated to preventative care as specified in Band 1(g). Renumber subsequent Schedules accordingly.

There has been criticism of the new contract because it does not put enough emphasis on preventative work. That criticism has been expressed not only by practicing dentists with NHS cases, but by academics at the dental school. With that in mind, and bearing in mind the philosophy of ‘Designed for Life’, which is that we aim to create a new generation of people with healthy teeth and so on, the purpose of the amendment is to change the bands of treatment so that it is possible for dentists to work in a purely preventative manner.

I notice from the Schedules, in relation to the bands of treatment, that the first band is called ‘diagnosis, treatment planning and maintenance’. It starts from the principle that you are going to need to have something done. It deals with clinical examination, and with various other types of examination, such as radiographic examination and so on. Band 1G refers to instruction in the prevention of dental and oral disease, including dietary advice and dental hygiene instruction. However, it does not appear to give any freedom to dentists purely to give instruction and assistance with dental hygiene. Going back to the previous amendment, which I am pleased was passed, and which allows an emphasis on children, this one is intended to give dentists the ability purely to give instruction on how to look after your teeth,

and to regard that as a unit of dental activity. I have not gone as far as trying to disentangle that in terms of schedules of how many units that would be; it would clearly be a simple, basic unit.

I am aware of work being done in west Wales—I think that it is in Pembrokeshire—where children are given toothbrushes and toothpaste, and are encouraged to use them. That kind of simple, basic instruction might not be done by the dentists themselves, but by a member of their team. The way forward envisaged in this contract is that there should be more of a team approach. Therefore, all I have done is to take out the references on the instruction on dental and oral disease and so on, and make it a separate band, so that, instead of having a simple three-band approach, you would have a fourth band, which would simply be advice and guidance.

Brian Gibbons: Certainly, Jenny is correct in that one of the points of the new dental contract is to allow the removal of the perverse incentive to be conservative that is in the present contract arrangements. There is an imperative, almost, in the contract to keep doing more and more activities, because they generate the fee. Clearly, that it is not in line with good current professional practice. However, I would have thought that, in all of the bands, prevention would be intrinsic to the treatment process—in other words, it is an in-built part of good professional practice—and that preventive activity should not be divorced in the way in which Jenny is suggesting.

Something like 50 per cent of the dental activity that takes place is in relation to examination, scaling, cleaning and so forth. As part of preventive activity, I would have thought that some sort of inspection would have to take place to kick-start any type of preventive advice. So, if we say that preventive advice must be linked to some sort of assessment of need, in terms of doing an oral inspection, then I think that this practice is actually included in that and there probably is no case for making prevention entirely separate from what should be intrinsic to good clinical practice.

Jenny Randerson: I am not totally reassured by the phrase ‘I would have thought’, because one of the issues that dentists have with the current NHS treadmill—as they call it, and they use that phrase all the time—is that they are not able to give enough time to preventative work. They have failed to be reassured that this contract gives enough time in the sun, as it were, for preventative work. What is constantly said is that they know what good clinical practice is, what is ideal, and what they have been taught that they should be doing, but the current situation, and how it appears to them that this situation will roll out, is such that they do not have the time to give to the kind of preventative work that I have outlined. It is just to give simple advice to people—and the important thing, Minister, is the large percentage of people who do not currently go to a dentist until they have a pain in their mouth. It is literally that, is it not? They do not go to the dentist until there is something seriously wrong. We are missing vast swathes of young people, who are not given proper oral hygiene instruction or instruction on how to care for their teeth. By the time that they get to the dentist for band 1 or band 2 treatment, it is going to be too late. This is an attempt to give dentists the freedom to go out and find the people who are not going to come for treatment until it is too late.

Brian Gibbons: One of the big drivers for this contract has been the National Institute for Health and Clinical Excellence guidance, and one would expect that the practice of dentists under this new contract would be in line with the NICE guidelines, which suggest a regular check-up on people’s teeth and oral cavities, in line with its clinical requirements. Dentists should work to the NICE guidelines, and band 1 will allow dentists to deliver what the NICE guidelines require in terms of a check-up.

10.30 a.m.

Therefore, even though people are having a check-up and getting a band 1 payment—and I appreciate your point that it is not called a check-up as it is part of a diagnostic category; in practice, it is a check-up as part of the preventative health work that the NICE guidelines recommend—it is included in this contract in that first band of payment. If dentists work to the NICE guidelines, people will be called back. For some people it will be six months, but for the vast majority, probably, it will be 12, 15 or 18 months, or even a longer interval. When they are called back, they will have a dental check-up, and the necessary advice for preventive activity will be given to them. There is a payment in band 1 precisely to do that, even though, as you say, prevention is not included in the rubric at the top of that banding. However, if people are working to the NICE guidelines, that is precisely what will happen.

David Melding: I will allow you to come back right at the end, if you want, Jenny.

Rhodri Glyn Thomas: Credaf fod y prosiect yr oedd Jenny yn cyfeirio ato yn sir Benfro yn cael ei gydlynu gan Her Iechyd Cymru, lle mae wedi dod â nifer o bobl at ei gilydd, gan gynnwys y bwrdd iechyd lleol, yr awdurdod lleol, a sawl corff arall, i gynnig pob math o anogaeth i bobl fyw bywyd iach. Mae elfennau o ddeintyddiaeth yn rhan o hynny.

Rhodri Glyn Thomas: I believe that the project to which Jenny referred in Pembrokeshire is co-ordinated by Health Challenge Wales, where it has brought many people together, including the local health board, the local authority and several other bodies, to offer all kinds of encouragement for people to live healthy lives. Elements of dentistry come into that.

Ymddengys ei bod yn fwy priodol gwneud y math o beth y mae Jenny yn ceisio ei hyrwyddo drwy'r gwelliant hwn yn y cyd-destun hwnnw. Mae modd ei wneud yn llawer mwy cyfannol yn y ffordd honno, na dim ond drwy bobl yn mynd i'r ddeintyddfa i'w wneud fel unigolion. Felly, er fy mod yn cytuno â'r hyn y mae Jenny yn ceisio ei hyrwyddo, nid wyf yn siŵr a fydd y gwelliant, fel rhan o'r rheoliadau, mor ddefnyddiol â hynny. Felly, ni fyddwn yn cefnogi'r gwelliant, ond ni fyddwn yn ei wrthwynebu ychwaith.

It appears that it is more appropriate to do the type of thing that Jenny is trying to promote through this amendment in that context. It could be done far more holistically in that way, rather than through people going to the dental surgery to do it as individuals. Therefore, although I agree with what Jenny is trying to promote, I am not sure whether the amendment, as part of the regulations, will be all that useful. Therefore, we will not support the amendment, but we will not oppose it either.

Brian Gibbons: As I understand it, this scheme in Pembrokeshire is part of the dental fissure sealant programme, and is outside the GDS contract anyway. Therefore, that type of innovative programme will not be affected by this. As you know, the dental fissure sealant programme is mainly concentrated on Communities First areas, and areas where there are high levels of dental need. While we will be looking at the dental fissure sealant programme, that will not be affected by these regulations.

Jonathan Morgan: I am not certain what the practical implication of this amendment being carried would be. The Minister has a point that there is provision in the contract to allow the preventative work that we would hope to see, but, let us face it, people go to their dentist either for a check-up or when they have a problem. People do not tend to go to doctors merely to have an MOT—they go when they have a problem. I can see that there is a preventative role there, but I am not sure what its practical consequences in terms of commissioning, provision or cost would be. I am satisfied at present that there is sufficient scope within the regulations to allow the preventative work, but I do not think that we will support this amendment.

David Melding: Jenny, do you want to sum up and indicate whether you are pressing the

amendment?

Jenny Randerson: I was intending that the dentist—or a member of the dental team—would be taken out of the surgery to go into schools and such places, to give that advice. I do not have support for the amendment, so I will not push it to a vote. Many LHB areas do not have the kinds of programmes to which I referred. Therefore, would it not be helpful if dentists got out from their surgeries, and ceased to be the people you only went to when you had a problem—and that is the truth of the matter for a very large percentage of the population—and went into schools to do that kind of preventative work? That was the intention of it. I will not push it to a vote because, clearly, I do not have the support of other parties.

Brian Gibbons: Jenny's point is valid, and that is why this type of prophylactic approach is one of the things that is being looked at in the review of the role of the community dental service. The CDS is the main delivery vehicle of the dental fissure sealant programme, but there are other preventative activity options, particularly with young children, people with learning disabilities, special needs and so on. I think that that will be picked up, and by strengthening the commissioning role of local health boards, they will be able to commission this type of service from what will, hopefully, be a strengthened CDS, in the light of the review that is going on as we speak.

David Melding: Thank you, Minister. The amendment is withdrawn and we move to points of clarification. They are numbered points from two to 11. I intend to take them sequentially as they are listed and I hope that we can be fairly brisk.

Jocelyn Davies: Do some of them not duplicate?

David Melding: If you think that they duplicate each other, please indicate that. I would rather not have an exhaustive round of supplementaries, so please only come in if you think it is essential, and then we should be able to get through the business in time to leave a short period at the end if there are more expansive or general remarks on dentistry that you would like the Minister to hear. First, we have Jenny Randerson on point 2.

Jenny Randerson: Looking at the charging guidelines and the possible charge bands, and the breadth of the bands of treatment, I notice that your ballpark figures for these are £12, £39 and £177. There are massive jumps between those figures. I would have thought, knowing human nature a little bit, that there is a likelihood that people could save up their treatment, especially if they are band 2 people. The sort of things included in band 2 mean that you have a bit of a problem, so you do not go and deal with it immediately because you would quite like to have two fillings done at the same time and, however many fillings you are going to need, you would probably be in band 2. Alternatively, people could go in and demand more treatment than they really need in order to get their money's worth out of it.

I am sure, Minister, that you will reply that there is good clinical practice and so on, but at the sharp end, dentists often feel that they are being pressurised by patients —as do GPs, consultants and all sorts of other people in the medical profession. These bands are very broad, and the price jump between them is considerable. I understand the simplicity—it is clearly much less bureaucratic and to be welcomed—but the broadness of the bands is such that there is a real doubt as to whether they are going to be effective. The simple question is, has there been any kind of pilot scheme, in Wales or in England, to assess whether these bands work and whether they are actually going to encourage, rather than deter, people.

10.40 a.m.

Brian Gibbons: The answer is 'no'; I do not think that any pilot scheme has been undertaken. To answer some of the points that Jenny made, this new contract helps by making it more

transparent and explicit in terms of the treatments that dentists will be giving to patients. Do not ask me in which section it appears, but there is reference to the fact that they only have to undertake activity to promote the dental health of the patient. So, if a person comes in looking for purely cosmetic activity, that is not covered under the contract. Dentists will be able to point out that this is not part of their mandatory services under this contract. Equally, for some activities, as long as it is transparent, and the patient gives informed consent, there is no reason why a patient could decide to have activity that could be available on the national health service done privately. That would also be all right, as long as it was made clear to the patient which options they could exercise.

The contract will be reviewed, and if abuse, in terms of people accumulating problems in the way you describe, materialises, it would be material evidence for any review. However, I am not really convinced that that will happen to any great extent. I may be wrong and you may be right, but I do not think that we can predict that yet. However, if that abuse were happening, hopefully, the review would be able to pick it up, address it and look at the contract accordingly.

Jenny Randerson: I am pretty appalled that there has been no pilot scheme. This is not a Welsh issue; this is an England and Wales issue. However, I am reassured by the fact that the Minister says that he is prepared to review the contract, because there might well be a need to do so. When I go to Tesco and buy two pounds of apples, I appreciate that I am going to pay more than if I bought a pound of apples. That is a simple approach to what you get for your money. Dentistry is different from other NHS work. You do not pay when you go to a GP, but people are paying for this. So, when people who are used to paying per filling are suddenly told that they will pay as much for one filling as they would for two or three, there will be public resistance to this. This will especially happen when you go from band 2 at £39, to band 3 at £177. That is an awful lot of money, and people will want to know why they are paying £177 for something that is relatively simple, when someone else that they know has paid £177 for something phenomenally complex. There is bound to be public resistance to this.

Brian Gibbons: I cannot add much more; the bandings were devised by the working party led by Harry Cayton. As I understand it, there were two British Dental Association representatives on that working party. A considerable amount of thought went into this. Clearly, there is an element of uncertainty, and an annual review is built in to this. People who will be paying will probably, as you say, have a slightly higher income, and, in general, people with a higher income have better dental health. So, the answer to the question of whether they will be accumulating fillings, and so forth, in the way that you describe, is ‘maybe’. We have to be open-minded; I do not think that it is going to be a big problem. However, if it is a big problem, that is why there will be annual reviews of the contract over the initial period. The reviews exist precisely to pick up these operational issues, as they come along.

David Melding: Do you have a brief supplementary, Rhodri?

Rhodri Glyn Thomas: Byddai’n fuddiol inni ddelio yn gyflym gyda phwyntiau 10 ac 11 yn awr, gan eu bod yn ymwneud â’r un pwnc. Yr hyn yr wyf yn ceisio’i wneud ym mhwynt 10, o ystyried yr hyn y mae’r Gweinidog wedi’i wneud, yw cael cadarnhad—yr wyf yn meddwl fy mod yn glir yn fy meddwl—nad oes cynlluniau peilot cyffredinol wedi eu cynnal o gwbl ar y cytundeb hwn, nid yn unig gyda’r bandiau, ond yn gyffredinol. Tybiaf mai dyna’r sefyllfa, o’r hyn mae’r

Rhodri Glyn Thomas: It would be beneficial if we were to deal quickly now with points 10 and 11, as they relate to the same issue. What I am seeking in point 10, given what the Minister has said, is confirmation—I believe that I am clear on this—that there have been no general pilot schemes on this contract, not just on the bands, but in general. I believe that that is the situation, from what the Minister has said, but he can respond on this. On point 11,

Gweinidog wedi'i ddweud, ond gall ef ymateb. Ar bwynt 11, o ystyried yr hyn a ddywedodd y Gweinidog am adolygu'r sefyllfa yn flynyddol, tybiaf fod hynny yn golygu, pe bai'n gweld y math o broblemau y cyfeiriodd Jenny atynt, sef bod pobl yn cael llawer o driniaeth o dan yr un band, a bod hynny'n creu problemau ariannol i'r deintyddion sy'n gorfod cyflwyno'r gwasanaeth hwnnw, y bydd modd adolygu'r bandiau yn y dyfodol ac, o bosibl, eu newid.

given what the Minister said about an annual review of the situation, I would assume that that means that, if he were to see the sorts of problems that Jenny referred to, in that people may have many treatments under the one band, and that that may create financial problems for dentists who are required to introduce this system, it will be possible in future to review the bands and, possibly, change them.

Hwyrach y gallwn ddelio â phwyntiau 10 ac 11 yn awr, Gadeirydd.

Perhaps we can deal with points 10 and 11 now, Chair.

David Melding: Thank you, Rhodri. You are right, it is appropriate. Minister?

Brian Gibbons: In response to Jenny, I took 'piloting' to mean piloting of the charges, which has not been undertaken. However, there has been a considerable number of pilots in relation to the PDS, and those pilots, with regard to the contract and the activity, have been going on for five or six years at least. In the last couple of years, as more and more people have gone over to the PDS pilot, a lot of the information picked up from these PDS pilots has fed into the contract development. In terms of the contract, it has been very much informed by the PDS pilots conducted, but for the charges, no, there has not been a pilot. However, I can give you an assurance with regard to the payments and so on that, if the three-band system is not sufficiently robust, or if there are abuses of it and so on, then we have to come back to it.

David Melding: Are you satisfied?

Rhodri Glyn Thomas: Yes.

David Melding: Jonathan Morgan, you wanted to raise point 3.

Jonathan Morgan: On the issue of the number of patients that you expect to register with an NHS dentist, as far as I am concerned, the contract is not just about a more sustainable future for dentistry and increasing the number of people who may wish to practise dentistry, but the way in which you foresee the increase in the number of people in Wales who are registered. Considering the rather poor number of people who are registered with a dentist, I think that you need to demonstrate the ambition—I do not like setting targets and timetables—in terms of getting people registered with a dentist. Now, I raised this matter because there are many dentists, including some people in the BDA, particularly in England, who say that they feel that a large number of dentists might leave the profession. If people leave the profession at a quicker rate than that at which you can recruit, then there will be a problem, if not a crisis. Therefore, how do you foresee this developing in terms of pure physical numbers in Wales? We know that roughly 50 per cent, or less than 50 per cent, are registered; will we start to see some movement in the right direction and, if so, what numbers are we looking at?

David Melding: Before the Minister replies, Rhodri has indicated that point 6 relates to this specific issue as well. Do you want to make your points now, Rhodri?

Rhodri Glyn Thomas: It was just to confirm Jonathan's remarks about the unmet need and any analysis that may have been made of that to try to work out how more people will want the service if it is available under the NHS. Clearly, people are having problems accessing it, and that is restricting the number of people using the service. I think, therefore, that the Minister can deal with points 6 and 7 now as well.

Brian Gibbons: There are around 180,000 patients in PDS practices in Wales, with an increase of 30,000 to 40,000 through increased access. In other words, it is 180,000 plus whatever proportion the 40,000 is in terms of increased access. Again, Rhodri Glyn asked about the experience from pilots. I do not think that there is anything peculiar about the practices that have gone over to PDS as we speak, so, hopefully, as more and more people either go to the PDS that are in the pipeline or move over to the GDS, there will be that access dividend. It may be a bit less in the real contract, but that is what is happening at the moment. I think that there will be an access dividend.

10.50 a.m.

As to how many people will eventually want to register with dentists, I asked this of a number of the dental groups that I met during discussions on the contract, and there is not a definite answer. Based on anecdotal experience, they suggested that probably two thirds of the population might want to have an NHS dentist. As I say, that is from anecdotal experience, rather than hard information. To promote people's dental health, we would like people to have access to NHS dentists. We are committed to trying to deliver that in the NHS. We do not have hard and fast empirical evidence, but that is the sort of figure that we have arrived at from people's response to that question.

Do you want me to deal with point 4, in relation to the Welsh dental initiative?

David Melding: I think that that takes us slightly further. Jonathan, are you happy with the general response from the Minister that, essentially, the service is demand-led, and that if everyone wants to register, they will aspire to meet that demand?

Jonathan Morgan: I am happy with that.

David Melding: Let us move to point 4.

Rhodri Glyn Thomas: First, on point 6, I accept what the Minister is saying about demand, but there is a specific question of how the funding will correspond to that. The Minister is accepting that there will be greater demand. He seems to be confident that the capacity will be there. I do not share that confidence.

David Melding: Minister, you said earlier that you anticipate that there may be an increase in the funding stream required to deliver this more comprehensive service.

Brian Gibbons: Yes. That is built into the draft budget. On point 6, there is an implementation board for the new dental contract, which has a finance sub-group. Among other things, it is considering the ways in which allocations can be made. I do not think that a definitive decision has been made on that. The type of options that might be considered would be the number of registrations in a local health board area or the number of dentists per head of population. There are epidemiological studies going on all the time, mainly done by the community dental service, into dental health in certain areas. So, you could equally use the prevalence of dental disease in an area based on the CDS epidemiological surveys. There are a number of ways in which this could be done. We have not made a definitive decision, but there is a finance sub-group looking at this to try to bottom it out.

On the cash limit, there is money in the pool to meet the current level of provision, and there will be the money that will be retained by LHBs between now and 1 April, even if a practice decides to leave the NHS now.

Rhodri Glyn Thomas: The Minister has started to address point 8, so perhaps he could deal

with that now.

David Melding: We will reach point 8, sequentially. You can probe him further in light of his answers. It is difficult to chair a session when we have a whole list of questions, many of which overlap. I see that Jenny wishes to speak. As we are in territory that she did not earlier indicate as being a point for clarification, I want to hear what she has to say.

Jenny Randerson: On a very simple point of clarification, the Minister referred to the fact that there is money in the budget for this next year. As we do not have our budget figures in front of us, can he clarify how much he has put in the budget for next year and the following two years?

Brian Gibbons: I think that there is something in the order of £12 million to £15 million for 2006-07. I do not know what is in the budget after that time.

Ms Lloyd: It is the same for 2007-08.

David Melding: We need to move on. Members can return to these issues in further points as they are listed. In fairness to the Minister, he is giving quite clear answers, though you may disagree with them. The policy direction has been illustrated with admirable clarity. We shall move to point 4.

Jonathan Morgan: We have not spent much time looking at the mechanics of the PDS and the Welsh dental initiative, and I am keen to understand how it fits together in a practical sense, in terms of the way in which PDS is used to increase the number of NHS patients in return for financial remuneration, but also the way in which the Welsh dental initiative works to help dental practices to make changes, so that they can cope with the additional capacity. What are the requirements for dental practitioners to receive that money to make those kinds of changes? I raise the issue because a dentist to whom I spoke had agreed with his local health board to increase the number of patients under PDS by some 1,500 to 2,000. He was then told, because he had been allocated money under the Welsh dental initiative, to make some changes to the practice. He then had to take on an additional 1,300 patients, but there was a great deal of uncertainty as to whether or not he would be paid for the patients. In terms of the pure mechanics of how this system works, I want some assurance that we are not asking dental practitioners to take on patients without proper remuneration.

Brian Gibbons: On your last point, in terms of access, it will be for the local health boards to look at the access requirements in their community. If there are access deficits, they should be contracting with the dentists in the community to meet those deficits. Clearly, that will involve providing money to the dentists to meet the access deficit.

The Welsh dental initiative and the new contract are not inextricably linked, so the Welsh dental initiative could satisfactorily continue in parallel with the present arrangements. I realise that the British Dental Association representatives are still here, so I do not want to put words in their mouths, but the BDA would not be averse to looking at the Welsh dental initiative, as we also want to do as an Assembly Government, to see whether we are getting best value from the scheme, particularly in the light of the new contractual arrangements. For the time being, the Welsh dental initiative will continue as a separate and parallel programme. Whether or not it is giving the best value for money, because of the new contract and the uptake and so forth, is something that we are quite willing to look at. Some people say that it is time to review it, and that it has served its purpose in terms of the returns for the money, but that is a pragmatic decision that we will take in the light of whatever consultation we have on the Welsh dental initiative.

Jonathan Morgan: I was just curious as to what the prerequisites were for money being

allocated to a dental practice under the Welsh dental initiative. Are practices being told, 'Yes, you can have this money under the dental initiative to help make changes to your practice, but you will have to take on an extra lump of patients in addition to the patients that you have agreed to under PDS', if they are engaged with PDS? Is that the case? A dentist told me that he was expecting to treat his extra 1,300 patients, effectively, free of charge.

Brian Gibbons: The point of the Welsh dental initiative was to provide a grant or payment to improve access for people who want to use the NHS. So, the purpose of the Welsh dental initiative is to improve access. It would be fair to say—and I would have thought it myself at some stage—that it was some kind of capital grant or equipment purchasing scheme, and so forth. However, when you look at it, it is somewhat more flexible than that. So, the purpose of the Welsh dental initiative is to improve access. If there are other mechanisms, through the new PDS or the GDS, to address access issues through direct commissioning, then the WDI might wither on the vine, or people might say, 'No, convert the WDI into a clear-cut capital grant for allocation to buildings or equipment or whatever'. The point you make is about access, and a local health board may take the view that, because we are giving extra payments to improve access, we will not be double paying them because, fundamentally, the WDI's purpose is to improve access.

11.00 a.m.

David Melding: The point is that if access is improved through extending the premises or whatever, and you are able to take 1,000 more patients, they come in and are charged through the system.

Brian Gibbons: I understand what you say, but it is important that, if a local health board is contracting for increased access and gives 'x' amount of money to a practice to deliver that increased access and that is the contract that has been agreed, then, whether or not you come back a second time and say, 'Right, we have agreed the contract, we now also want Welsh dental initiative money to achieve precisely the same purpose.'—

Jonathan Morgan: But it is a different purpose, is it not? In terms of personal dental services, the dental practice has paid for those additional patients. That money is to cover the cost of treatment; it is not—but correct if I am wrong—to help that dental practice to increase its capacity, or its physical size.

Brian Gibbons: It could be.

Jonathan Morgan: It could, could it?

Brian Gibbons: Yes.

Mr Powell-Chandler: There are a couple of instances in which they do not sit well together. The Welsh dental initiative provides a sum of money for access over a certain period. Traditionally, it is 1,300 patients for five years. Personal dental service schemes do not quite sit in the same way. We have had one or two instances in which it may well be the case that, as you say, dentists have had discussions with local health boards about grant payments that are outstanding and they have also wanted to take on PDS. We are looking at that because, as the Minister was saying, they do not sit well together and we need to have a look at the terms and conditions of the Welsh dental initiative, which was set up around 1996, so things have moved on quite a lot since then. We are aware of one or two cases, which we are looking at individually.

David Melding: We ought to chase that up by other means because I fear that we would get into quite a lot of tangential detail if we were to pursue it. Jonathan, do you want to comment

on point 5?

Jonathan Morgan: I will be very brief on this, because it is, in essence, covered by Rhodri's point 6. You have already confirmed that this is demand-led and that the additional resources will be put in. We have budget reviews from one financial year to the next, but if there is a surge in demand mid-year, how would local health boards access additional resources to cope with the additional demand? Would they have to wait until the end of the financial year and for the next financial year for those budget considerations? I accept that, if it is demand-led, it is terrific if the funding is there, but, if it is in between the budget processes, what happens if a local health board is facing a particularly difficult financial constraint because it has had a surge in demand in its area? Does it access extra funds?

Brian Gibbons: No. In general, the position would be that, if we had an outbreak of seasonal flu this winter, the local health boards and the local health community would have to manage that within the allocation that they had at the beginning of the year. The same principle would apply in dentistry. There may be exceptional circumstances in which we would have to make a pragmatic decision but, by and large, the situation for general dental services will be no different from that of general medical services in that the local health boards' good and prudent management has to be able to cover contingencies. That is why people have contingency funds and put them to one side to address unanticipated demand. However, I am not being dogmatic. I cannot think of an example, but if there were a set of completely exceptional circumstances that created the situation that you describe, that would be fine, but the default position will be that people will need to be engaged in proper financial planning, with contingency funds and so forth, to address unpredicted requirements.

David Melding: Rhodri Glyn, do you have a comment on point 8?

Rhodri Glyn Thomas: Mae hyn i'w wneud â thaliadau hefyd. Mae'r rheolidau hyn yn sôn am nifer y cleifion sydd wedi cofrestru gyda deintyddfa. Mae'n bosibl i fwy nag un bwrdd iechyd lleol ymwneud â'r sefyllfa. Os ystyriwch ddyffryn Aman, gwelwch y gallai deintyddfa yno fod yn ymwneud â phedwar bwrdd iechyd lleol gwahanol—tri yn sicr, ond pedwar o bosibl. Sut y byddwch yn sicrhau bod y byrddau iechyd hynny'n cydweithio ar hyn, oherwydd yr oeddech yn sôn yn gynharach yn y drafodaeth hon mai mater o flaenoriaeth i'r byrddau iechyd lleol ydyw? Mewn sefyllfa felly, gallai blaenoriaethau'r byrddau iechyd fod yn dra gwahanol o ran deintyddiaeth, oherwydd natur yr ardaloedd y maent yn ymwneud â hwy. Sut mae modd sicrhau bod y sefyllfa gyllidol yn cael ei diogelu ar draws ffiniau y byrddau iechyd?

Rhodri Glyn Thomas: This is also to do with payments. These regulations talk about the number of patients registered with a dentist. It is possible for more than one local health board to be involved in the situation. If you consider the Amman valley, you see that a dental practice there could be involved in four different local health boards—three certainly, but possibly four. How will you ensure that those health boards collaborate on this, because earlier in this discussion you mentioned that this is a matter of priority to the LHBs? In such a situation, the priorities of the LHBs could be very different in terms of dentistry, because of the nature of the areas that they deal with. How can you ensure that the funding situation is safeguarded across local health board boundaries?

Brian Gibbons: While I remain committed to the LHB model, I would agree that there is room for improved commissioning within LHBs, which is one reason why, as part of 'Designed for Life', we announced new commissioning guidance yesterday. There is no doubt in my mind that local health boards will have to co-operate much more effectively across boundaries and borders when commissioning services. This applies in the specific instance that you raised, but it is not just confined to this. As part of 'Designed for Life' and 'Making the Connections', local health boards must start to get out of their geographical

boxes and start looking more widely to create a more coherent commissioning range of activity across borders. I think that, in a number of areas, the local health boards are probably not too resilient at commissioning certain types of services, simply because of the geographical constraints. So, that is a disadvantage of the present LHB structure, even though, on balance, the strengths are there.

I think that dentistry and the issue in the Amman valley that you raised is the type of issue on which local health boards need to work together. That is only one example; there are many others where the current geographical boundaries are not adequate for effective commissioning, and, hopefully, the new commissioning guidance will be picking this up. The expectation, even now, is that local health boards have to demonstrate that they are working together across boundaries, if that makes sense in a commissioning context.

Rhodri Glyn Thomas: Yn sicr, yr wyf yn gwerthfawrogi yn fawr gydnabyddiaeth y Gweinidog fod problemau o ran comisiynu gan fyrddau iechyd lleol. Yr wyf yn ei chael hi braidd yn anodd derbyn bod y Gweinidog yn dweud bod yn rhaid i'r byrddau iechyd lleol ddod allan o'u blychau daearyddol er mai'r Llywodraeth sydd wedi eu gosod yn y blychau hynny. Fodd bynnag, yr wyf yn gwerthfawrogi yr hyn y mae wedi ei ddweud ynghylch comisiynu yn gyffredinol a'r ffaith ei fod yn ymwybodol o'r problemau allai godi o ran deintyddiaeth. Yr wyf yn siŵr y gallwn ddod yn ôl at y pwynt hwnnw y tu allan i'r pwyllgor hwn.

Rhodri Glyn Thomas: I certainly greatly appreciate the acknowledgement from the Minister that there are problems in terms of commissioning by local health boards. I find it slightly difficult to accept that the Minister says that local health boards have to get out of their geographical boxes when it is this Government that has put them in those boxes in the first place. However, I appreciate what he said on commissioning generally and the fact that he is aware of the problems that could arise in terms of dentistry. I am sure that we can come back to that point outside of this committee.

O ran pwynt 9, yr wyf yn ymwneud—

In terms of point 9, I am involved—

David Melding: Sorry, Rhodri, but I have had an indication on point 8, which I will now take.

Jenny Randerson: I am being parochial about this. I have real concerns about the situation that will occur in Cardiff, and I am sure that the same would apply to Newport, Swansea and Wrexham, and, to a certain extent, other towns. An awful lot of people choose their dentist so that they can get there during the working day, and, therefore, they do not live in that area. Clearly, in the case of Cardiff, there will be a massive inflow of people, and I am extremely worried that, because of the point that Rhodri raised, the financial impact on the LHB will be considerable. Is that going to be taken into account in terms of the funding? If they are going to commission services on a catchment-area basis rather than on a residential basis, who will pay the subsidy for the treatment of the NHS patients who come from all around Cardiff but who do not live in Cardiff?

11.10 a.m.

Brian Gibbons: I know that this is a capital-city issue, and I suppose that other parts of Wales address it in other ways, for example, during the holiday season when there is a variation in the population base. This is one of the challenges that Peter Townsend faces in trying to come up with the direct-needs formula for allocating resources in general, so I think that this is a general challenge to any resource allocation mechanism. However, the answer, specifically, is that responsibility rests with the person's residential local health board. There is no reason why a health board has to specifically commission services within its own geographical boundary. Much of a local health board's powers extend to commissioning all

the secondary services outside its geographical boundaries, so that is going on all the time. So, on the example that you mentioned, if a particular Caerphilly LHB, through its needs assessment, understood that people were using Cardiff dentists, then the challenge for it would be to commission accordingly.

Jenny Randerson: I am a specific resident who lives in Caerphilly, but my dentist has always been in Cardiff. Will I no longer be able to go to my Cardiff dentist to get NHS service and treatment unless Caerphilly chooses to commission that service?

Mr Powell-Chandler: The position, as it stands, will not change. If you have always been going from Caerphilly to Cardiff, then the money will be with that Cardiff dentist, so that will be covered. The Minister was referring to additional resources if there was to be an influx. The situation that you describe has already happened—it happens a great deal in Cardiff and Swansea, where they take people on from outside the area. The funding will be with the LHB on historic grounds. At the moment, the funding mechanism works so that when the existing dental budget—the £80 million plus that the Minister mentioned—is distributed, it will go to those areas that currently get it. The challenge or difficulty, and where the Minister has referred to the additional money, is what happens when we want to grow additional services. In the case that you describe, if you are in Caerphilly and come to Cardiff, things will continue as normal and the money will stay with the practice in Cardiff and with the Cardiff Local Health Board.

David Melding: Finally, Rhodri Glyn wishes to speak on point 9.

Rhodri Glyn Thomas: This point of clarification is specifically about the frequency of check-ups, but I would like the Minister to take it in the context that the regulations are target-driven. Concerns have already been raised about payment and single and multiple treatments, but there is genuine concern among dentists about the lack of flexibility in the way in which they carry out their work within the new contract. There is real concern that the ability to make clinical decisions has been taken away from them. So how do you envisage the new regulations affecting the frequency of check-ups? Will that now be a purely clinical decision or will it be driven by the targets and the other elements of the regulations that affect funding and flexibility?

Brian Gibbons: The whole point of the new contract is to provide that professional flexibility. The only target-driven activity—Andrew may want to elaborate on this later—is that dentists, under current contracts, have to achieve a unit of dental activity that is 10 per cent less than the current activity as measured through the UDAs. Other than that, it is down to the dentist's professional judgment in line with the National Institute of Clinical Excellence guidelines and his or her own clinical expertise to decide the frequency of these examinations. I will ask Andrew whether there is anything that he can add to this, but, other than the requirement to meet the workload expectation, there are no driven targets in that sense.

Mr Powell-Chandler: It is a question of clinical freedom. As the Minister says, the new NICE guidelines are moving away from the standard six-monthly check-up to whatever the dentist and patient decide is best for that patient. For some, it might be less than six months, but it looks likely that more appointments will be given every nine, 12 or 18 months, or whatever is appropriate for that individual patient. That is a decision for the dentist, as the clinician, to make.

Rhodri Glyn Thomas: I listened with interest to what the Minister said, and also to what Andrew said, and I presume that I am getting an undertaking from you, Minister, that those decisions will be purely clinical, and will not be driven by any other factors.

Brian Gibbons: As I said, the only requirement in the contract is that they reach the 90 per

cent conversion, with the plus or minus 5 per cent tolerance, which is more generous in Wales than what resulted from the discussions in England. That is the only hard target, if you want to describe it in that way.

David Melding: Thank you. That concludes the scrutiny of which we have given the Minister notice. I indicated to Members that there may be some time to look at some other general points. I cannot determine whether the Minister will be able to respond immediately—and far less require that—as he has not been notified. However, I am keen to take other points, as we have time.

Val Lloyd: Thank you for agreeing to take these points. My question relates to personal dental services. It came to my attention on Monday that some practices that operate personal dental services are charging adult patients £35 to access a place. The LHB confirmed that this is possible under the current PDS, and it is to deal with the cost of providing new facilities and to cover the administration costs of registration. I have looked many times through the regulations in front of us that relate to the new PDS contract, and I have failed to find anything relating to that charge. That could be my inefficiency, and so I would like to raise the issue of whether that is admissible under the new contract.

Mr Powell-Chandler: It is not specifically in the new contract; it is something that goes on, and we are aware that it happens with existing GDS contracts, and that dentists sometimes ask patients to pay a charge. It is sometimes offset against future treatment, and it is to try to get around the problems of people who book an appointment and then do not attend, and the impact that that might have on the dentist's business. It might be referred to in a PDS pilot scheme, but it is not intended to be a part of the new PDS or GDS schemes. It is something that is currently practised by some.

Val Lloyd: To clarify, I understand what you said about defraying the costs incurred when people do not turn up, but it is inequitable if it is levied across the board. You do not know whether that person will turn up or not.

Mr Powell-Chandler: We would not condone that action. I would have to check, but I do not think that the General Dental Council would condone it either. However, it is not outside of what dentists are able to do. It is done by some practices. We have heard of instances in which it has happened in the past. It is not something that is being introduced by the new regulations.

David Melding: Are there any other general points before we move to the next item of business?

Rhodri Glyn Thomas: I have a specific question about charge exemptions for the under-25s and the over-60s. How will that tie into the proposed band 1 dental treatment charges?

Mr Powell-Chandler: The current exemptions, whether for under-25s or over-60s or anyone else who is entitled to free dental treatment, will continue. Those people would still be entitled to a free examination. Any additional costs would be charged as they are at the moment.

David Melding: No-one has indicated that they would like to make any further points. Can I therefore conclude that we are content with these regulations as amended and clarified? I see that we are.

Tynnwyd y gwelliant yn ôl.
Amendment withdrawn.

11.20 a.m.

Mesur Iawndal y GIG
The NHS Redress Bill

David Melding: We have five points of clarification, but perhaps the Minister would like to make a few introductory remarks before I move to those.

Brian Gibbons: I would just like to highlight that this is a fairly historic moment in devolution. This particular Bill has the first framework clause in it, which is appropriate, as health is one of the areas in which we have greatest autonomy. It should not be a surprise that health is one of the areas in which we are first offering to make use of the framework legislation. In applying for framework legislation, we must justify why we are asking for it, and in view of the work that is going on in Wales in developing our own specific redress schemes, we felt that there should not be an automatic sign-up to what is being proposed in the UK legislation. That could compromise, in some way, the work that is being done on the ground, particularly the development of the speedy resolution scheme, which is being piloted at the moment in Wales, and reasonably good progress is being made. There were also some concerns about the perceived independence of what is being proposed in England, insofar as the trusts are very much in the driving seat in terms of initiating and carrying through the redress procedures, and I understand that this point was raised in the Second Reading when this legislation came before the Houses of Parliament. The concern there is also shared by other people. Asking for framework legislation gave us the opportunity of keeping our options open to pursue a wide range of different solutions here in Wales, should we wish to do so.

It is too early to be prescriptive, other than to say that work is going on in terms of improving complaints activity and the speedy resolution scheme. It is too early to be too prescriptive in saying how we want to use the framework clause at this stage, but, hopefully, through developing a culture of openness in dealing with complaints, and by working through the pilots, we will be able to have the type of pilot experience to really put flesh on the framework clause that we have. In conclusion, Chair, this is a practical example of the evolution of devolution and partnership working between Westminster and Cardiff bay, and it places a responsibility on us, as legislators in the National Assembly, to demonstrate that we have the capacity to respond to this new challenge and opportunity. I am sure, on the basis of the work that is in hand, that we will be able to rise to the challenge and demonstrate that we are capable of using this opportunity and come up with concrete proposals that will provide redress for those who, in other circumstances, would have to resort to the expense and uncertainty involved in a court resolution of their legitimate complaints.

David Melding: Thank you, Minister. We move therefore to points of clarification.

Rhodri Glyn Thomas: The first point is very specific, in terms of the timetable. Do you have a proposed timetable, Minister, of how this will develop and when it will be in place?

Brian Gibbons: No, it is very much, in the first instance, determined by the legislative programme in the Houses of Parliament. Until the legislation goes through, we are not in a position to put flesh on our particular proposals. However, while that is going on, clearly we will be learning the lessons of the pilot schemes that are going on, also based on the experience of the complaints procedures and so on. Also, a new culture is emerging, with the NHS engaging with the National Patient Safety Agency, so we are certainly a couple of years away from anything definitely happening, but that will not be wasted time because experience and information will be gathered over that period.

David Melding: Rhodri, did you want to come in on point 2?

Rhodri Glyn Thomas: I think that point 2 has been dealt with.

Point 3 is about clause 17, which allows a wider remit in Wales in terms of the redress scheme. You will have to look at results from the pilot schemes to see how that can be implemented, but I take it, Minister, that you are open-minded in terms of having a far more wide-ranging scheme in Wales?

Brian Gibbons: Yes.

Rhodri Glyn Thomas: My specific point is this: do you have any intention of including the primary sector in the redress scheme, and how will you do that? As it stands, it does not cover the primary sector, does it?

Brian Gibbons: No. The English proposals do not cover the primary care sector. It is an option for us, and I suppose that our preference would be to have a more all-encompassing scheme. However, there are particular problems. Whereas the hospital scheme is mainly funded, for example, through the Welsh Risk Pool, most GP coverage comes through the Medical Defence Union and the Medical Protection Society, and so on. Therefore, there are such technical issues that would have to be sorted out. As there is not total symmetry between the two systems, there will be issues to be sorted.

Jenny Randerson: Point 4 follows closely on from what you have just said, because this does not include GPs. When you refer to problems with including GPs, one understands the practicality of those issues. However, are you, in principle, in favour of including GPs? The point that I raise in my point of clarification is that 'Designed for Life' is looking towards more and more procedures that used to take place in a hospital now taking place in primary care, and therefore there will be an issue about crossover treatments; minor surgery that could take place in a hospital in one LHB area could take place in a GP's surgery in another area. You will then get unevenness across Wales in the way in which this applies.

Brian Gibbons: The preference would be that we would have a single comprehensive scheme; it makes sense. It would be difficult for the public to understand the technical reasons if we split it up. That would be our preferred option. However, I do not want to commit us irrevocably to that at this stage, but that would be our point of departure, to see whether we could deliver that.

Jenny Randerson: I will move on to point 5. I greatly welcome the framework powers, and I hope that the Minister will celebrate by having a truly distinct, better and Welsh answer to the problem. I welcome the concept that people will have an alternative to costly legal procedures. One thing that I have come across with many constituents is their failure to understand the current complaints procedures and the interface between complaints procedures and redress. Point 5 asks whether there is anything in the Bill that will help to secure a more integrated approach between complaint and redress. It seems to me, from following several cases through, that people often start with wanting to make a complaint, and their frustration at the complaints system drives them into seeking redress per se, and seeking a legal solution. Many people, if the complaints procedures were properly laid out and well integrated with the redress procedures, would be satisfied at a much earlier stage, which would be good for the NHS and for them. Therefore, what is in this current Bill that might do that, and are you thinking of something similar in Wales?

11.30 a.m.

Brian Gibbons: I do not want to say too much about what is in the Bill from the Westminster point of view. However, I think that we would support your general point that, as part of the complaints procedure, that should lead to greater openness. Part of the thinking behind the

speedy resolution is to respond to where damage might have occurred through negligence and so forth. I think that the two things very much complement each other. I do not think that you can underestimate the culture change that this will require from people working in the health service. I speak from personal experience: for most clinicians, when complaints are lodged against them, it is a pretty shattering experience. I spoke to a nurse last week who was devastated about it. It almost knocked the nurse out of proper functioning for nine or 12 months, until the complaint was satisfactorily resolved. As it is so shattering for people, it creates an extremely defensive position, and we must be able to create a culture in the NHS in which people recognise that the people providing the service are human, that everybody, no matter how well motivated, will make mistakes, and that engaging more openly means that people will not commit suicide, which happens at the present time. Achieving that culture change will be a massive job. The national patient safety agency is contributing to that because the number of clinicians who are reporting adverse incidents is quite impressive; that degree of openness exists and, hopefully, this is part of a changing culture, in which professional people will not feel that they are all-powerful and that they can never make a mistake. We need to be able to achieve that, but I do not want to underestimate how difficult that will be for some people. It will be difficult, but we want to try to move in that direction if at all possible.

Jonathan Morgan: I have a brief point on this issue. I heard what the Minister said, and he is right, but as an Assembly Member, I have heard of far too many cases through my postbag that have led to many patients testing their own faith in the health service. Sadly, many of those cases could probably have been resolved much earlier, but they had been allowed to get out of hand. Where we could do some additional work, in addition to this redress Bill, is to see how we foresee the future for community health councils in Wales, for example. As independent organisations, they can very often calm the situation quite considerably, but we need, at some point, to look at the capacity of the CHCs to cope with their workload. Increasingly, I am finding more complex cases are now being dealt with by the CHCs, which require a great deal more time. It is not just an issue of writing a quick letter to the trust to establish the facts, but is quite complex and deals with detailed information. At some point, we will have to look at the role of CHCs in the context of this Bill.

Brian Gibbons: That is a fair point; again, I cannot quite remember—

Ms Attwell-Thomas: That is certainly part of the plan. All this work has already started on the need to review the existing complaints procedure and align it much more closely with what happens when something goes wrong. In that way, you are more proactive upfront, telling patients, working with them and involving them in the investigation so that they do not have to make a formal complaint. Alongside that, as you are aware, we have developed the advocacy service within the CHCs, and we are reviewing that at the moment to see where it is going, what are the issues around capacity, and how we take that further. So, a lot of that work is already in train. A lot of the building blocks are in place, so, hopefully, in the next couple of years, we will get to a position wherein we will have an all-embracing redress arrangement in Wales.

Rhodri Glyn Thomas: I support Jonathan's point about the CHCs. That must be reviewed because there is a need to build up the capacity; the resource must be there to deal with these issues. I am reassured by what the Minister said about the need for trusts to try to deal with these issues much quicker. I have just had a case where it has taken me two years to get a meeting. Had I had that meeting immediately when I asked for it two years ago, this problem would not have existed. I hope that the Minister will be actively pursuing this in order to deal with the way in which some administrators within trusts try to avoid the issue, rather than addressing it.

David Melding: I do not see that any other Members want to raise points, so I will conclude,

Minister, by saying that the committee is interested in this area, and looks forward to the specific structure of this scheme, as you bring it forward in secondary legislation. That will, no doubt, be subjected to some detailed scrutiny in the committee.

There are two papers to note, namely the ministerial update, and the minutes of our meeting on 3 November. I have one item of other business, which is just to remind Members that there will be a presentation by Homeless Link Cymru on Wednesday, 30 November, at 12.30 p.m. in conference room C. Members of the Social Justice and Regeneration Committee have also been invited to attend. I encourage Members to attend. Do you have anything to add on this?

Jonathan Morgan: It is not on this, but I have one further item of business.

I understand that three members of this committee will not be rejoining the health committee in the new year, including you, Chair. I wanted to place on record my thanks to you for having chaired this committee annoyingly impartially, from our perspective, over the past two and a half years. You have been a superb Chairman, and have, of course, been on the committee for six and a half years; we should place on record our thanks to you for the work that you have undertaken on this committee, and wish you well in your new position. I also thank Jocelyn Davies, who I understand is leaving, and Val Lloyd—I think that covers everyone.

David Melding: All three of us are deeply grateful for those kind remarks. I am tempted not to go around the table, as that would be embarrassing.

Jonathan Morgan: Oh, go on.

David Melding: Perhaps Members can express any thoughts that they have in private afterwards, unless it is essential that they speak now.

Rhodri Glyn Thomas: I would like to put on record my appreciation, Chair, of the annoyingly impartial—I agree with Jonathan—but also highly professional and effective work that you have done.

David Melding: You are very kind.

Brian Gibbons: We will miss the expertise brought by Jocelyn and Val to the committee, which will be difficult to replace. In addition to your knowledge of the subject, which has been of great assistance, the way in which you have chaired the committee has allowed for its smooth running. I wish that your future may be as successful as your present.

David Melding: I add my thanks to you all; it has been a pleasure to Chair the committee, as it was to serve on the first committee from 1999 to 2003. I add my deep personal thanks to Jane Westlake, the clerk, and to Claire Morris, the deputy clerk. Insofar as I have appeared professional—it is very kind of you to say that I have done so, at times, at least—it is the back-up and support that I have received from the secretariat, which, inevitably, Members do not really see, that have allowed the operation to work efficiently. I also thank Kathryn Potter and her colleagues at the Members' Research Service, who have developed excellent briefing materials that have allowed us to do some first-class scrutiny. Without further ado, I conclude this meeting of the Health and Social Services Committee, wishing the new, reconstituted committee, in the new year, every success, and the new chairman success in that role.

Daeth y cyfarfod i ben am 11.39 a.m.
The meeting ended at 11.39 a.m.