Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Mercher, 4 Tachwedd 2009
Wednesday, 4 November 2009

Cynnwys
Contents

4 Cyflwyniad ac Ymddiheuriadau
Introduction and Apologies

4 Ymchwiliad i Wasanaethau Strôc: Tystiolaeth gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
Inquiry into Stroke Services: Evidence from the Minister for Health and Social Services

20 Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol—Sesiwn Graffu Gyffredinol
The Minister for Health and Social Services—General Scrutiny Session

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'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Irene James	Llafur Labour
Ann Jones	Llafur Labour
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Simon Dean	Cyfarwyddwr, Strategaeth a Chynllunio, Yr Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Director, Strategy and Planning, Health and Social Services Department, Welsh Assembly Government
Edwina Hart	Aelod y Cynulliad, Llafur (y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Minister for Health and Social Services)
Paul Williams	Prif Weithredwr, Y Gwasanaeth Iechyd Gwladol (GIG) Cymru, Llywodraeth Cynulliad Cymru Chief Executive, National Health Service (NHS) Wales, Welsh Assembly Government

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

Carolyn Eason	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Steve George	Gwasanaeth y Pwyllgorau Committee Service
Martin Jennings	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Claire Morris	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 10.31 a.m.
The meeting began at 10.31 a.m.

Cyflwyniad ac Ymddiheuriadau
Introduction and Apologies

[1] **Darren Millar:** Good morning, everyone. I welcome you to this meeting of the Health, Wellbeing and Local Government Committee. I welcome members of the public and remind them that headsets for simultaneous translation and sound amplification are available in the public gallery. If anyone has any problems when using them, the ushers will be able to help. Simultaneous translation is available on channel 1, and amplification of the language that is being spoken is available on channel 0. I ask everyone to ensure that all mobile phones, BlackBerrys and pagers are switched off, so that they do not interfere with the broadcasting equipment. If it is necessary to evacuate the room or the public gallery in the event of an emergency, the ushers will guide everyone to the appropriate exit. Finally, I remind everyone that the microphones are operated remotely and there is no need to press any buttons.

[2] I have been notified of one apology, from Helen Mary Jones. She may be able to join us later on in the meeting, but she will not be here for the start—indeed, she may not be able to make it to the meeting later either. I invite Members to make declarations of interest under Standing Order No. 31.6. I see that there are no such declarations.

[3] Before we go on to the next item, I welcome Claire Morris, who is the committee's new clerk. Claire is likely to be with us until Christmas. We are delighted to have her on board. We are very sad to see Steve George move on. He is taking up his new role with the Subordinate Legislation Committee, as it is currently titled. Steve is sitting in today because he wants to pick up on the evidence for the report on stroke services, which will be drafted soon.

10.32 a.m.

Ymchwiliad i Wasanaethau Strôc: Tystiolaeth gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
Inquiry into Stroke Services: Evidence from the Minister for Health and Social Services

[4] **Darren Millar:** This is the committee's final oral evidence-gathering session as part of its inquiry into stroke services, and I am delighted that Edwina Hart, the Minister for Health and Social Services, is with us today, along with Paul Williams, the chief executive of the national health service in Wales, and Simon Dean, the director of strategy and planning for the Welsh Government's health and social services department.

[5] As usual, we have received an evidence paper from the Minister, which has been circulated to committee members as paper 1. Given the time constraints this morning, we would like to move straight to questions. I will start.

[6] Minister, witnesses who have attended the committee during the course of the inquiry have asked for a specific stroke strategy, almost without exception. As reasons for that, they cited things such as the appropriateness of the national service framework for older people, saying that it is not focused to a sufficient degree on stroke. They also mentioned the fact that many younger people these days are suffering strokes, and there is a need for a greater degree of focus on that. What are your views on that? You do not seem to make them clear in the paper that you have submitted.

[7] **The Minister for Health and Social Services (Edwina Hart):** I disagree with the views that have been expressed to you. I have set a clear policy direction by publishing the formal programme of work to improve stroke services; I have set a target for acute care, and have set a deadline of 2015 for meeting all published national standards for stroke care. I have done a sufficient amount with regard to how I wish to develop the service.

[8] **Darren Millar:** It is clear, though, that the witnesses who have given evidence to us do not feel that you have gone far enough. They feel that the older people's strategy and the national service framework within it does not focus sufficiently on stroke, and certainly does not encompass the broad age range of people who suffer strokes and the needs that they have.

[9] **Edwina Hart:** There must, therefore, be a fundamental misunderstanding of the NSF, because the national service framework for older people sets standards for stroke care, which are the standards in respect of all people who require stroke care. I have put considerable additional funding into this agenda: £2.5 million in 2008-09 in terms of services and £2.275 million of that has gone directly into front-line services. I have also funded national initiatives to raise awareness and to support the NHS in achieving improvements, which it is starting to achieve.

[10] **Darren Millar:** So how are we going to get this necessary focus on younger people who suffer from stroke, for example?

[11] **Edwina Hart:** How to deal with that is a clinical issue within the local health boards. This is not new stuff to clinicians and NHS managers. The resources are made available; they know what they need to do in terms of the configuration of beds and services that are required in LHBs to give a better sense of delivery, and they just have to get on with it. The policy direction has been quite clearly set by the centre.

[12] **Lorraine Barrett:** You just started talking about the targets. Will you say something about what the targets include and how you intend to monitor them? When do you think it would be possible to see some results of the work?

[13] **Edwina Hart:** I am in the process of developing the so-called intelligent targets for inclusion in the 2010-11 annual operating framework. I do not know whether the director of the NHS wants to comment further on the target position.

[14] **Mr Williams:** The Minister talked about engaging the clinicians in developing the 2015 targets because we need to look across the whole spectrum. We have, obviously, concentrated on the acute interventions, and we might want to talk about that in terms of our progress. However, we are looking through from the whole issue of public health into prevention and planning. These intelligent targets will tell us much more about the outcomes and quality of care rather than just numbers. Numbers are important—we need to have co-located beds; a simple target—and we need to look at the quality of the outcomes and work with the clinicians through intelligent targets, so that we look at what we are doing about making sure that we have effective intervention by speech therapists, for example. It is a very subtle approach underneath some very clear targets, particularly around the co-location of stroke units themselves.

[15] **Edwina Hart:** 'Intelligent targets' is a very new phrase. Would it be helpful, Chair, if I arranged for the officials who are working on it, together with the clinicians, to prepare a briefing on the nature of intelligent targets for the committee? You could get to grips, probably in an hour, with how it affects and impacts upon not only stroke services, but all NHS targets. I think that that would give greater clarity.

[16] **Darren Millar:** That would be very helpful indeed, Minister.

[17] **Lorraine Barrett:** Looking at the improving stroke services programme, what have you achieved to date, and are there any areas under that services programme that are particularly concerning to you?

[18] **Edwina Hart:** Yes, there are areas of concern. The pace of improvement is too slow; there is the whole issue around 24/7 CT scanning and access, which is an important area within this. Referrals to clinical psychology can take a long time, which is a UK problem, and not simply a Welsh problem. However, in real terms, the swallowing issues around stroke assessment are being dealt with within 24 hours. The time from presentation at accident and emergency departments to admission to co-located beds has definitely improved. The percentage of patients who have manual handling assessments within 72 hours has also improved, which is key to stroke service development. The percentage of patients who are sat out of bed or mobilised within 72 hours has improved, and the percentage of patients who have multi-disciplinary goals set within the first seven days has also improved. We must continue to press the NHS to achieve compliance with the national standards all the time, and I am ensuring that they have robust delivery plans on the standards by 2015. That is right, is it not, Paul?

[19] **Mr Williams:** Yes.

[20] **Edwina Hart:** I have agreed to organise a campaign in 2010 on identifying high blood pressure. There is also a national programme on the intelligent targets that we have looked at before. We have also looked at the whole issue of the seven days following a stroke, and from day seven to week eight in terms of the rehabilitation agenda. All health boards and the 17 hospitals have complied with the co-located beds since October 2009. We have full compliance in the Aneurin Bevan Local Health Board, in the Nevill Hall Hospital and the Royal Gwent Hospital. In Abertawe Bro Morgannwg University Health Board, the Princess of Wales Hospital, Singleton Hospital and Morriston Hospital are compliant. We have had full compliance in Cwm Taf Local Health Board in the Royal Glamorgan Hospital and Prince Charles Hospital. In Cardiff and Vale University Health Board, there has been near compliance, but we will be chasing that up with the University Hospital of Wales and Llandough Hospital. Betsi Cadwaladr University Local Health Board will have full compliance in January, with Ysbyty Glan Clwyd, Wrexham Maelor Hospital and Ysbyty Gwynedd. However, there is significantly more work to be done in Hywel Dda Health Board. We are concerned about how Withybush, Bronglais, West Wales and Prince Philip hospitals will deal with the compliance issues. Some of the difficulties there have been the recruitment of doctors, occupational therapists, physiotherapists, dieticians and psychologists. There is a big issue there about access to 24-hour brain scanning, because there would have to be significant capital investments. It would also be necessary then to provide radiologists and radiographers.

10.40 a.m.

[21] I have asked the stroke partnership that we have established to monitor all of this, but some of this is far more challenging in rural areas, including the ambulance response times when a rapid response is required in some of the rural areas. So, I hope that when Elystan Morgan finally finishes his response to the rural health plan, we might be able to deal with some of these rural issues linking into the treatment of stroke, such as ambulance services.

[22] So, good progress has been made to date in some areas, but there is a lot of work to be done within Hywel Dda LHB and to ensure that Betsi Cadwaladr University LHB in north Wales meets those targets by the January target. As the director of the NHS, you are continuing to press this, are you not, Paul?

[23] **Mr Williams:** Yes.

[24] **Darren Millar:** You have cited lots of improvements that are positive and which we welcome as a committee. We know that you commissioned work to support the stroke services improvement project, which is being run by the stroke partnership, which included a stroke collaborative for measuring improvements and that report has been completed, but has not yet been published, or it is certainly not in the public domain. Is that right?

[25] **Mr Williams:** That is right.

[26] **Darren Millar:** Why has that not been made public?

[27] **Mr Williams:** A methodology is being developed that would help us to monitor progress and make further improvements. The methodology is not currently sufficiently robust for us to use to plan. It is work in progress.

[28] **Darren Millar:** So, there is no reason not to publish that information, is there?

[29] **Mr Williams:** There is no reason to publish information that is flawed. It is work in progress. This is not an exact science.

[30] **Darren Millar:** A critical friend might suggest that there might be something embarrassing in there that you do not want people to see.

[31] **Edwina Hart:** For heaven's sake. Chair, I do not intend to publish work that does not stand up to scrutiny. This is ongoing work. I know that people might want it faster, and want it to be done, but I want it to be better and for it to be correct so that it is useful for us as we develop services. I receive papers every day and some are drafted up to nine times because they are not satisfactory, will not stand up to public scrutiny and will not work. I want anything that I produce to be valid in order to deliver a good service.

[32] **Darren Millar:** With respect, Minister, your paper quotes many of the improvements that are no doubt reported in the report that you suggest is not robust in terms of the quality of the information.

[33] **Edwina Hart:** The methodology of taking it forward is what we will look at. Am I correct, chief executive?

[34] **Mr Williams:** There are two issues relating to monitoring the progress that we have made on the plan and developing a methodology that will take us into the 2015 territory that the Minister referred to. That is work in progress. There is nothing to hide there; there is no point in bringing something to the committee that is not complete.

[35] **Darren Millar:** If the information is robust, which is what you seem to be saying, Minister, or the methodology—

[36] **Mr Williams:** I said that the methodology is being developed.

[37] **Darren Millar:** Okay, but you are citing the areas where improvements have been made, and you say that that information is robust, but you are also being critical about the information that is being gathered.

[38] **Mr Williams:** No, they are two different things.

[39] **Darren Millar:** If the quality of the data is not there, then it is not there, is it, and the

information is not valid? It is either valid or it is not.

[40] **Mr Williams:** We were pursuing the progress on the annual operating framework target, which we can talk about in considerable detail, as the Minister has already done. However, through the stroke partnership and the work being done there, we can look at further ways that we can enhance and monitor this programme of work.

[41] **Darren Millar:** So, you do not intend to publish that information or ensure that that information is available in the public domain at all?

[42] **Mr Williams:** When it is robust.

[43] **Darren Millar:** When is that likely to be?

[44] **Mr Williams:** I would think that it would be within the next couple of months.

[45] **Darren Millar:** This is obviously an important stroke inquiry and that information would certainly be helpful to us, as a committee, in drawing our conclusions and recommendations.

[46] **Mr Williams:** Yes, but, again, it is important to recognise that it is within the 2015 target. This is work in progress. We are talking about tangible progress in terms of the 20 targets set in the AOF.

[47] **Andrew R.T. Davies:** Thank you, Minister and your officials, for attending this morning's meeting. Before the half-term recess, Dai Lloyd and I visited the CRI—other Members were also invited—to look at the multidisciplinary rehabilitation team there. Much of the evidence that we have received in this inquiry has identified shortcomings in being able to access good quality aftercare. For example, the team that we visited in the CRI is sadly not replicated across the whole of Wales. The lack of psychologists was made to us forcibly. As a lay person looking in, I could appreciate the vital role that the psychologist plays in pulling all of that together. We were told that if you went anywhere else in Wales, you would not find that particular speciality.

[48] So, given the evidence and what we have experienced first hand, the crucial point about developing stroke services is being able to attract and develop the staff structures to facilitate the improvements that we want to see in patient outcomes and quality of life. What measures are the Welsh Assembly Government undertaking to address these shortcomings and, in particular, to attract the quality staff—of course, all staff are of a good quality, but I am talking about the quality that we need to ensure that we get the multidisciplinary teams to function on the ground?

[49] **Edwina Hart:** When I answered Lorraine's question, I alluded to the fact that one area of concern for me is the clinical psychology agenda because that is a problem across the UK. So, you are right in saying that we will have to do more to attract staff. What you were told when you visited the CRI is what I am told when I visit, namely the need to get the quality staff and the correct staff in position. We have prioritised improvements on the acute side quite well in the days immediately following a stroke and the AOF targets for acute stroke have to be achieved. Self-assessment shows improvement and, as I indicated in my previous response, quite large chunks of Wales are doing well in this, but Hywel Dda LHB, Powys Teaching LHB and Betsi Cadwaladr University LHB are not quite where they need to be and will not be there until around January 2010.

[50] This raises the issue of whether there are alternative ways to organise secondary care around stroke care. Therefore, your points are well made and we are trying to prioritise the

recruitment of staff in this area and to get everything together in one place so that we can make it work. However, I accept that there is still a point about the fact that we cannot get the staff in this particular discipline.

[51] **Andrew R.T. Davies:** I hear what you say about doing more, but could we have a taste of what 'more' means? What sort of initiatives are coming from the Welsh Assembly Government to enable you to work with the local health boards to attract these staff and to create and fund these positions? Could you give us examples of initiatives to provide the necessary resources? I heard what you said earlier to the Chair—that you provide the targets and that it is then up to the LHBs to get on with things, but, frankly, if they do not have the resources to do so, it is quite difficult for them to get on with things.

[52] **Edwina Hart:** I think that the LHBs have the resources and I do not think that all of them have been particularly innovative, over the years, in dealing with these matters. They have taken far too long to bring together the multidisciplinary teams in some areas. There are some fine examples in Gwent, where excellent work has been done and where those teams have been brought together quickly and have started to manage the service. This is not always about money, but about how you organise the working patterns of staff and of service delivery in the hospital where things are focused and centred. So, it is not a money issue. There is a shortage in some disciplines, which is difficult for all involved, particularly in the field of clinical psychology. We have said to the LHBs that they have to start to make people understand that Wales is an attractive place in which to work. We have the necessary resources and we are running departments that they want to be part of. So, while we encourage from the centre, it is their job to manage what we have established in policy terms and to get on with it. Additional cash has been put into the system for them; they have been lucky. Many others are reorganising their services without any additional cash to enhance that process; they are being told to just get on with things. We are talking about substantial budgets in these LHBs, which allow them to prioritise appropriately, in my view.

[53] **Andrew R.T. Davies:** If I may labour the point, I did not hear you mention an initiative that would supplement this issue of doing more. We agree on the point that we need to get the multidisciplinary teams up and running and that we need to be proactive about attracting staff to provide this service and the speed of service is critical.

10.50 a.m.

[54] I did not hear anything in your answer about initiative, but perhaps I missed it. Could you elaborate on the initiative side of things?

[55] **Edwina Hart:** We have established a speech and language therapist two-year postgraduate programme. We dealt with that in particular so that we could get more speech and language therapists into the system. That is an example of an initiative that the Welsh Assembly Government has taken that we hope will help with stroke services in the long term. There are little bits and pieces across the piece that go to make the whole. I do not know whether there is anything else to say, Paul.

[56] **Mr Williams:** I think that that is a very good example. As the Minister said, we are running huge organisations now that are responsible for the recruitment and retention of staff. Where we need a national programme, like a programme for speech and language therapists, we are ensuring that that is there for those organisations to draw on.

[57] **Andrew R.T. Davies:** Some of the evidence that we have received has highlighted that co-located beds are no substitute for stroke units in terms of the ability to respond quickly and to develop services. Do you accept that evidence? I appreciate that there are limits to what we can deliver. We are all aware of the difficulties with the geographical location of certain

communities in Wales, especially with rurality and so on. However, at the end of the day, surely the aspiration would be to have stroke units that are accessible to all communities in Wales rather than the co-located bed model.

[58] **Mr Williams:** That is an interesting concept that we will need to explore as we review and evaluate the effectiveness of the programme. Co-location stroke units are a combination of facilities, including beds, diagnostics and therapeutic facilities. In some places it is possible to have them under one roof and in others it is possible to have them next door to each other. However, in a rural environment you have a combination of factors and, in fact, the Wales ambulance service will play a key role as part of such a stroke unit. As the new health boards start to come together, they will have a different view on how those facilities should be provided for their populations compared to the way that 22 commissioners with 11 trusts saw it. As we evaluate the programme, we will probably see further proposals coming forward on how we can consolidate this concept. We have to be careful as it would be very easy to say that we want to centralise everything, but we also have the issue of accessibility. These issues will have to be played out and the local health boards are now looking at this and will be evaluating it as part of the stroke partnership work.

[59] **Edwina Hart:** The establishment of a multidisciplinary team and co-located beds is a fundamental requirement of a stroke unit. There are also other issues that impact on the units far more, such as timely access to decision making, CT scanning and a dedicated stroke team. That is what makes up the unit; it is not necessarily four beds in a walled unit where you can say, 'That's the stroke unit'. It is about how the services combine and come together. As we develop this and give a continuing priority to stroke units, we will get to grips with some of the wider issues that you have raised. When you look at a new build in the future or when you undertake alterations to buildings and so on, you might decide to look at this and at how you would review your definition of your stroke unit in its location.

[60] **Darren Millar:** That is incredibly important because the stroke unit has been a theme in the evidence that we have received so far, particularly in the evidence from Sweden, where it was the establishment of stroke units that drove up the improvements in stroke care and the outcomes for patients. So, thank you for that, Minister. Ann Jones, I know that you want to explore staffing a little further.

[61] **Ann Jones:** We have been told that the shortage of staff specialising in stroke appears to be across the board in Wales. We have been told that there is not one medical consultant stroke specialist post in Wales. Often, the consultants who treat patients with stroke do it because of a personal interest. Not one consultant is funded to undertake stroke medicine on a full-time basis. That has been cited as one of the reasons why Wales lags behind in all areas of stroke provision. How can you ensure that medical consultant stroke specialist posts are created in Wales and can therefore take us forward?

[62] **Edwina Hart:** The issue that you have raised is common across the whole of the United Kingdom. The reality is that it is quite normal for geriatricians, acute physicians and neurologists to have stroke as an additional specialism. That could be seen as a strength, not a weakness, in our endeavours to look at a successful multidisciplinary and professional approach to these complex medical issues.

[63] **Ann Jones:** So, you see it as a strength that there is a multidisciplinary approach.

[64] **Edwina Hart:** I think that you can see it as a strength. It is common across the UK; it is not just the Welsh position.

[65] **Ann Jones:** There are no medical stroke training posts for doctors and it has been suggested that doctors who have an interest in stroke are not attracted to come to work in

Wales. I heard what you said about the fact that we should be attracting people to Wales, and certainly to the Betsi Cadwaladr—or the BCU, as I know it, because I cannot remember its full title. It is a marvellous place to go to, but it is obvious that we are not creating the training posts. How can we create them? How can we resolve this?

[66] **Mr Williams:** I was talking to the post-graduate dean with the chief medical officer yesterday about how we need to align our plans in stroke care, for instance, much more with our training to ensure that we deliver. In the past, we have not made those connections as we should have, so I am keen to ensure that we now have an effective service and workforce plan in which these issues are connected.

[67] **Edwina Hart:** The fact that we have prioritised this service will enable the LHBs to respond to this new agenda and have honest discussions with the deanery about what they want in terms of training posts and so on.

[68] **Ann Jones:** In looking at creating training posts, I make a plea that we do not just look at universities in south Wales, but at medical schools in the north-west, particularly for north Wales. It seems silly to have someone who goes to medical school in Cardiff coming to do a placement in north Wales, as that person would have to leave all his or her friends and social life down in Cardiff, which is four hours away, when you have medical schools in the north-west, offering another pool of people for us to look at. Unfortunately, that is not the case at the moment.

[69] **Edwina Hart:** We have been in correspondence on this particular issue, Ann. I am due to meet the deanery at some time, and I would be happy to raise the points about training, because it is important that we get people in, particularly in the north-west, as with the south-west, to take advantage of what is available.

[70] **Mr Williams:** I referred to recruitment and retention in an earlier response, and this is very apposite with regard to medical staff. I was talking to the dean about that issue, too, yesterday, with regard to whether some of our training rotas are attractive. If medical staff do not have a good experience when we train them, they might not wish to come back to Wales. This is very much at the forefront of my agenda of issues for next year.

[71] **Ann Jones:** Thanks; I am pleased with that.

[72] On nurses and therapists, you have mentioned a two-year course for speech and language therapists, but nurses and therapists have told us yet again that they do not believe that there are enough specialised stroke posts to bring Wales up to the desired standard. Given that you are putting this two-year course on, are you absolutely confident that the course will be adequate to provide the level of speech and language therapy needed for patient support? Patients get frustrated and upset that they cannot get access to these people because, for them, the therapy is often their way back into society, and without it, they feel held back. That is most frustrating for patients.

[73] **Edwina Hart:** We allocated an additional £2.275 million so that they could look at enhancing the multidisciplinary teams in terms of recruitment across the piece. Some of the additional staff that they were looking at were in speech and language therapy. We hope that the course that we are putting in place will help us to meet demand, but you are quite right that it is an area of concern for patients, who want to once again be able to communicate as they used to before having a stroke.

[74] There are other areas of concern for us, however, such as the use of physiotherapists. Dieticians are another group that feels that more resources are required, and we are looking at healthcare support workers, who also play a valuable role in care, as well as specialist nurses

and rehabilitation assistants, who are also now in the framework for development. I do acknowledge what you said about speech and language therapy in particular. The ratio in the system to deal with stroke victims is currently poor, and we have acknowledged that, which is why we have put the plan into action. To be frank, speech and language therapists have raised this with us on a number of occasions, because they are eager to attract more people into the profession to deal with their work at the sharp end.

[75] **Mr Williams:** It is important that, in the design of the new health boards, we have a director for therapies and health sciences to ensure that, at board level, these important professions are recognised for their contribution.

[76] **Edwina Hart:** That was not necessarily the case in the old structure, and when we made the changes, they lobbied hard to have therapies on the board. I think that it will make a tremendous difference to these therapies, which play a key role in stroke services and the delivery of treatment. Before, they felt that they had no voice, but at least they will have a voice in discussions now, such as when the board discusses financial priorities. They will be there on behalf of patients and their profession to make the case in areas that have not been so popular in health in dealing with the stroke service. The trouble is that people have traditionally looked at stroke and said 'Someone's old, they have had a stroke, what do we do?', whereas we need to be far more proactive than we have ever been on this particular agenda.

11.00 a.m.

[77] **Andrew R.T. Davies:** In response to Ann's questions, we have heard a lot about training and attracting staff into Wales, which we all subscribe to. However, in his evidence to the Finance Committee, Paul Davies, representing Welsh NHS finance directors, said with regard to training and appointing staff that:

[78] 'We have to restrict the appointment of staff—there is no doubt about that. We have to review areas such as study leave.'

[79] These are all tenets of recruitment, if you like. If you are going to attract people to work in the service, study leave especially will be attractive for people to come to work in Wales, because they will broaden their experience and enhance their ability to develop their careers. However, the people who handle the resources are saying that it will not happen.

[80] **Edwina Hart:** He might be the finance director, but there are also human resources directors involved in LHB boards. We have given guarantees and I am very keen for study leave to continue for the enhancement of staff training. He might be looking at it from a financial perspective, but he is only one member of that board, and we give the general direction of travel from the centre. We will be protecting all of these issues. Finance directors in their sackcloth and ashes do not look particularly attractive to me. I am delighted that they have said that these percentage figures exist for savings, and I am sure that we will be able to get those savings from them, which might help their performance appraisal. If they cannot deliver on what they told the Finance Committee, I shall be a very disappointed Minister, because I look forward to having the money that they can allegedly identify to put into front-line services. When you are very well paid and you are part of a management structure and you make these public statements, you should make sure that you can deliver on them.

[81] **Andrew R.T. Davies:** I congratulate you on that very robust answer, Minister, because if 20 per cent of your budget is sloshing around, going to the wrong places, even from an opposition politician's perspective you would think twice. It goes back to the point that training is an issue in all disciplines, but particularly in stroke services. Do you see any correlation between what has been submitted in evidence to the Finance Committee and what

you believe the Welsh NHS, particularly with regard to stroke services, will be able to deliver?

[82] **Edwina Hart:** I have made it quite clear in relation to training that I have been most dissatisfied with the way in which some LHBs have treated staff, not giving them time off to undertake training and making it very difficult for them to access courses. That must stop in the NHS. Staff need to be properly trained and they do not need to be told that, because they are having a morning off, they are expected to come into work in the afternoon. That is not on as far as we in the centre are concerned, and we have given strict instructions via our director of HR that this is not to happen. So, I do not see an issue on this. If you do not invest in staff training, you are not investing in the future of the NHS. That was an accountant's position, but, at the end of the day, the NHS is not about accountants, but the provision of services. Do you want to comment, Paul?

[83] **Mr Williams:** The finance directors might have been expressing an opinion, but they were not expressing a policy. It would be a disaster if we went for short-termism. We have to invest in the training and development of our staff, because they are our key resource.

[84] **Darren Millar:** Thank you for your answers on that, Minister. As an accountant—[*Laughter*.] Given that there is a recruitment freeze in some LHBs in north Wales at the moment because of the budgetary difficulties that they are experiencing, how will that help you to deliver some of these objectives? We have talked a lot about recruitment and attracting new people in, but if there is a recruitment freeze, will that not jeopardise some of the things that you want to achieve in terms of the improvement in stroke services?

[85] **Edwina Hart:** We understand that LHBs are currently looking at their staff requirements. They are new organisations, only established on 1 October, so it is only right and proper that they look at how they manage their budgets and staff recruitment. In terms of the management of their budgets, we are confident that some of them will come through a very difficult position, especially as the finance directors have indicated that there is spare cash and capacity within the system. I am sure that they will come out the other end on it. So, it is difficult, and I understand why they are at looking at these issues at the moment. However, in the long run, they have to look to anything that they save on their budgets going, as you said, directly into the front line to ensure that we have sufficient staff to manage these key services. The director and chief executive of the NHS is currently monitoring this.

[86] **Mr Williams:** To add to that, there has been a recruitment freeze on management costs, because we do not have a redundancy policy, and we have to redeploy those staff within an envelope. I would not expect, in a general freeze on staff recruitment, that front-line staff would necessarily be affected. I have worked in situations in which we have had a freeze on staff recruitment, but every week we would go through what the key front-line priorities were. We are not telling each health board how to do it, but, as the Minister said, it is a mechanism for living within their means and they have to do more than one thing. They have to do more than manage the books; they have to deliver the Minister's targets in terms of patient improvement and patient access.

[87] **Peter Black:** Following the theme of the research and training, healthcare professionals have pointed out to us in evidence that there is a lack of resources and opportunities for undertaking the research that they claim drives up the standards and quality of care. Do you agree with that claim and how do you intend to develop a research culture in which high-quality staff are, in turn, attracted to Wales?

[88] **Edwina Hart:** We have a stroke research network that pulls together clinicians and other stakeholders. I understand from clinicians that the network is proactive in addressing research needs, but, in light of your question, when I speak again with them, it is a point that I

will take up if there are concerns arising from your report.

[89] **Peter Black:** We have also had evidence from the college of occupational therapists that stated that the Wales Stroke Alliance education sub-group is an excellent network to support stroke education. It says that it has developed new links with the National Leadership and Innovation Agency for Healthcare and Agored Cymru and is seeking accreditation for a national stroke competence training programme. However, the college of occupational therapists says that there is a problem with a lack of funding to pay whoever delivers the training in each organisation and for backfill of staff time to ensure that treatment continues. How do you envisage lifting those barriers to training and ensuring that the work that is being undertaken is expanded?

[90] **Edwina Hart:** Your question raises an issue that is directly for the seven LHBs about how we would expect them to respond appropriately to the issues raised by speech and language therapists, with which I have enormous sympathy. I agree with the direction of travel in what they are saying. When we will raise this in our discussions with LHB chairs, I will ensure that that point is dealt with robustly.

[91] **David Lloyd:** On the stroke review, we have heard a lot about acute services and the need to be proactive and get there in the first 24 hours, and, doubtless, we will return to that later. In terms of community services and rehabilitation, which may be known as the softer services but are no less important, I would contend, we have received evidence from the college of occupational therapists that:

[92] 'There are insufficient community services to achieve early supported discharge.'

[93] I am aware from the voluntary sector business that I have dealt with recently that Age Concern and British Red Cross both provide early hospital discharge services to support people who are being discharged from hospital. That evidence and what is already in place through the voluntary sector seems to indicate that there are insufficient early supported discharge schemes. How do you intend to develop that end of the patient pathway?

[94] **Edwina Hart:** This is one of the key issues that LHBs will have to look at when they look at the development of primary and community services, instead of the almost total focus that we have had on secondary care in the last 10 years. Primary and community services have lost out, not only in terms of resources, but in an understanding of their needs and requirements. So, I am not surprised at you, as a GP, asking this question. Community rehabilitation will need to be developed to ensure that patients return to independent living. LHBs will have to have robust plans in place and hold discussions with their key stakeholders, namely the voluntary sector and local government.

[95] Some of the work that we are doing on chronic condition management to develop the primary and community services will also support those improvements. They have a deadline to meet, namely to achieve the national standards by 2015 to deal with the whole of the stroke patient pathway. However, a lot of work will be needed in that area to develop these types of services, because provision is very patchy. They are at a low level in some areas while things are better in others, but if we make them part of the targets and the planning for the LHBs, they will have to get to that 2015 target and they will have to be innovative in dealing with their partners to look at what is on the plate. I am not certain that people even know what is on the ground in terms of a mapping exercise. I think that local health boards will have to map very carefully what exists within the voluntary sector so that they can actually do the links. We do not need duplication; we just need to ensure that there is coverage via a variety of means.

11.10 a.m.

[96] **David Lloyd:** Following on from that, general practitioners and all of us in primary and community care are a shy, timid lot. We sometimes have issues as regards being swallowed up, as it were, by new health boards in terms of being dominated by secondary care. We see quite a few assurances that that would not be the case, but we still have those insecurities as general practitioners, and that is translated into what will happen in those long-term community services on the ground. I am happy with that answer, but we also have carers and the stroke patients that they care and who face social inclusion issues, particularly in rural areas, and we have social service departments. There is the old chestnut about the health and social service interface. There is not meant to be one, but obviously there is one and it is not going away. In terms of the whole development of the new health boards now, primary and community healthcare would like some reassurance that they will not be swallowed up, but primary care and secondary care are of equal validity and importance, particularly in terms of developing additional services to ensure that community rehabilitation takes place post-stroke.

[97] **Edwina Hart:** The rural health plan has started to focus on some of the issues within rural areas, but you are going into a much wider agenda here, which is our relationship with local government on the provision of social care and various services for elderly people. We have put additional investment into this agenda and we have looked for innovation from local authorities in terms of how it is spent. However, they have a long way to go. Some local authorities are very good when it comes to the delivery of these services. Others will have to think strategically about the partnerships that they will all require to deal with this. Where some talk about partnerships, others just do not do partnerships. I think that health has been quite guilty of this in the past, but it will not be in future. It is now a matter for us to get the appropriate arrangements with local government in place.

[98] Like you, I was worried when we did the reforms about what would happen and whether it would be swallowed up. I do not think that it will be swallowed up; I think that it is moving in the other direction. We have quite powerful forces on the boards in terms of the development of primary and community care. We also have on our side the citizens of Wales who agree with the notion of providing primary and community care services as close to them as possible. I think that the citizens of Wales also agree on the importance of public health and other issues with the new structures. I think that we have had quite a turnaround in people's concept of health. When the national health service was started, according to elder relatives of mine, people loved to stay in hospital. They went into a hospital; it was nice, and they had the food, the attention and so forth, but that view seems to have reversed totally and everyone now wants to stay at home if they can. We have to reflect that point in terms of how we develop policy.

[99] **Andrew R.T. Davies:** On that point, one of the pieces of evidence that we received, which relates to the structures in Northern Ireland, was about the working relationship for social services and stroke services. In Northern Ireland, there is 100 per cent coverage due to the structures. In Wales, I think that there was just below 50 per cent coverage. You touched on the point that local authorities and the new bodies must now have appropriate arrangements in place. In lay terms, what are 'appropriate arrangements'? How do you see the development of those arrangements so that we deal with that figure of below 50 per cent? The link created by social services taking people into the community is a key pathway, is it not?

[100] **Edwina Hart:** It is a part of patient care pathways.

[101] **Andrew R.T. Davies:** How do you see them developing those relationships?

[102] **Mr Williams:** We have the primary and community care strategy, which has been developed by Dr Chris Jones. Within that strategy, we see the importance of developing

integrated health and social care teams at the local level. Depending on which community you are looking at, it may be a 25,000, 30,000 or 50,000 hub. To develop that concept of integrated care teams—as the Minister said, to make sure that patients can be looked after in their homes, or as near to their homes as possible—the concept is now being discharged throughout Wales through desktop exercises with our partner organisations, and we are reinforcing that through the local service boards. We also have a very good initiative—the executive leadership group—which comprises of senior officers and chief executives from the whole public sector in Wales. That group looks at ways of providing seamless services for citizens, as there are different structures. Two excellent pieces of work are to start—one in Bridgend and one in Torfaen—and the intention is to roll that out.

[103] There is a lot to do here, but we are very encouraged by the way in which we have established the new local health boards. The structures are much more favourable to the concept of primary and community care and to the whole issue of collaboration and the reinforcement of the local service boards, and the way to improve our response to difficult resource situations in future will be through integrated care. So, there is a lot to play for here, but I think that we have got the structures right and are getting the policies to deliver on it.

[104] **Edwina Hart:** May I make a further point on this, Chair? This work is ongoing and it will be very good, but the proof of the pudding will be in the eating, when we actually implement all of this. We really need to serve notice to the organisations concerned that this is the direction of travel, and it is important for them to recognise that we must move from the desktop exercises to the reality, because patients are getting caught up in the middle of this, without the proper flow of services. This is a very difficult agenda, but we seem to have all the partners signed up to it.

[105] **Darren Millar:** Has the primary and community care strategy been published? Is it now a document that is out there that people are trying to deliver?

[106] **Mr Williams:** Yes.

[107] **Darren Millar:** Okay, thank you; I appreciate that. Val Lloyd has the next questions.

[108] **Val Lloyd:** I have questions on investment. You spoke earlier about investment, and I am aware that, in any comparisons, like may not always be compared with like. Wales does appear to have the lowest level of identifiable financial investment in stroke services within the UK, and I wonder whether you could comment on that. At the same time, you told us in point 3 of your paper about the £2.5 million of recurrent funding given to the former local health boards to provide additional staff to care for stroke patients and to the improvement project. Can you tell us, more specifically, how many new posts have been created as a result of this investment, and where are they placed?

[109] **Edwina Hart:** I have invested in a number of stroke-related interventions, but, for the most part, I have allowed local services to decide the best way of spending the funding. Some areas needed capital funding for scanning equipment, some have used it to increase therapy time and others have appointed additional consultants across the piece. I would be more than happy, if you want any further detail on this to help you with your report, to give you a note on what is happening in the LHBs.

[110] Our service workforce and financial strategic framework has focused on a whole load of issues and the expert panel has given advice on what to do. I have also supported campaigns with the Stroke Association Cymru and others. When you look at the investments that have gone into CT and MRI scanning across the piece, you will see that we are talking about millions of pounds-worth of investment that will aid stroke services. If the committee requires any detail, I am more than happy for officials to put it into some sort of format to see

what positive work the LHBs have done. That would be a good exercise for us as well.

[111] **Val Lloyd:** That would be helpful and would add to our paper. You tell us that there has been capital investment for new equipment and that you will be making further money available for a prevention campaign. What other plans do you have to invest in stroke services, and do they include plans to ring-fence allocations to LHBs?

[112] **Edwina Hart:** They are not ring-fenced at the moment, but I will look at how successful I have been with the ring-fencing of mental health money, because that will give me a good example of how attention has been focused. There are obviously new governance arrangements in place for the LHBs, and we will have to see how it goes. However, I do intend to steer quite actively the investment patterns in this area for the LHBs, because we can do that from the centre, and I am absolutely certain that the LHBs will be responsive to my prioritisation of this service. It is a key issue for chief executives delivering these particular goals.

11.20 a.m.

[113] **David Lloyd:** Turning once again to the immediate stroke situation—and we have touched on this—as you will be aware, a stroke can be caused either by a clot or a haemorrhage, and in terms of thrombolysis, obviously we just want to administer that to people who have had a clot, because otherwise you could make the haemorrhage situation far worse, and you can only sort that out by CT and MRI scanning. You have talked about increased investment, and everything is developing positively, but are there areas where CT and MRI scanning is not available 24/7 in Wales?

[114] **Edwina Hart:** We are currently looking at the issue, and the on-call arrangements for radiologists, and trying to provide timely access to CT scans. We have had some success in moving organisations from nine-to-five to 24/7 provision, except, I have to say, in some of the smaller district general hospitals. However, with the larger hospitals, this is something that we can do. In areas with less critical mass, we now have Tom Hughes and Anna Freeman looking at the pathway with the Welsh Ambulance Service NHS Trust to provide appropriate access, and this work should be completed in three months' time, so we should see an improvement. We are also running some trial work on thrombolysis with Edinburgh University, and I would be happy to update you on that when all of this is completed.

[115] **David Lloyd:** We have also heard evidence that there are fast-track protocols in place between the ambulance service and hospitals for patients with suspected stroke in the acute situation. However, that is not the case throughout Wales, so what are you doing to ensure that all acute hospitals develop such fast-track protocols?

[116] **Edwina Hart:** We have done well in collaborating successfully on a project with clinicians to encourage improvements in these key areas. We have a national protocol and quality requirements for the thrombolysis service, and the Welsh ambulance trust has confirmed that the rapid response is in place. It is part of its service improvement project. Do you want to say something about that, Simon?

[117] **Mr Dean:** I would just echo that, if I may, Chair. The trust has a specific protocol where suspected stroke is involved, and the other aspect of this is rapid and direct admission through accident and emergency units at district general hospitals. That is another area where there has been good progress; we just need to finalise work on that.

[118] **David Lloyd:** On the back of that, what has been done to ensure that all unscheduled emergency services are able to triage and deliver suspected stroke or TIA patients to hospital as fast as possible?

[119] **Edwina Hart:** That is part of the agreement.

[120] **Mr Dean:** It is part of the work that the LHBs are undertaking. If I may, I will link that to the intelligent targets work, because the key element there is about developing care bundles, so it is about getting clinicians of all disciplines to think through the pathway of care that a patient needs, from the immediate acute phase right through to rehabilitation. It is not just about developing numerical targets—it is about thinking carefully about how the organisation is working. One of the things to emerge through that work is a change in the way services are configured, freeing up existing resource for the stroke service. It is a very important process, which will also lead to measurable outcomes. That process is critical as well.

[121] **David Lloyd:** As a final question on this series of issues, what consideration has been given to using the air ambulance? I am well aware that we could do with more of them; it is basically a charitable institution, so what consideration should be given to using air ambulances in the emergency situation of getting people to a CT or an MRI scan within minutes?

[122] **Mr Dean:** The use of the air ambulance is part of the overall protocol with the ambulance service trust. Deployment is agreed between those two organisations. I agree that it has a key role to play.

[123] **Edwina Hart:** The ambulance trust is now quite clear on the services that need to be delivered at district general hospitals to provide the appropriate care.

[124] **Darren Millar:** This issue of the air ambulance is critical. When we took evidence from experts in Sweden, we expected to hear that telemedicine was important for delivering the service in rural areas, but it became clear that it was the use of air ambulances that made the big difference. They are achieving much more success in rural areas than in some of the urban areas as a direct result of the use of the air ambulance. We may well make some recommendations in that area—I do not know at present. However, it is good to hear that work is being done to develop protocols to ensure that the air ambulance service is used where appropriate.

[125] **Edwina Hart:** Of course, we must acknowledge the direct comparison between Sweden and Wales, given their rurality.

[126] **Darren Millar:** Yes, there are some direct comparisons to be made between the deep rural areas in both countries. We drew that from the evidence that we received.

[127] **Irene James:** I want to look at the idea of setting up a stroke register. You just mentioned Sweden, and we heard about how the Riks-Stroke register in Sweden is used to document a number of things and to help with treatment provision and outcomes. It was also responsible for driving up standards and encouraging research. Outcome data are important and provide a measure for improving services. Do you agree that we should have a stroke register in Wales? If not, how else might outcome data be used to evidence improving services?

[128] **Edwina Hart:** I have asked the chief medical officer to consider whether there is a need for a stroke register on the basis of clinical judgment. He will report back to me, and I will then advise the committee.

[129] **Darren Millar:** How long will it be before he reports back?

[130] **Edwina Hart:** He should not be too long.

[131] **Darren Millar:** It was seen as a key factor in driving improvements.

[132] **Edwina Hart:** I appreciate that.

[133] **Ann Jones:** He read your mind.

[134] **Irene James:** Yes, he did. In giving oral evidence, a number of witnesses have stated that stroke services suffer from a lack of leadership, possibly due to a number of different bodies in Wales having roles in improving services. Suggestions to remedy this include a single body, person or champion. Do you have any plans to ensure that a recognisable leadership role is established?

[135] **Edwina Hart:** The executive and clinical champions have been put in place in each local health board to lead on stroke services. We have done it from the centre. Simon Dean is the director for strategy and planning; Richard Bowen is the director of operations; and Dr Stephen Hunter is medical director. They provide the national leadership on stroke.

[136] **Irene James:** I think that it has already been agreed—and you have said several times—that there is still a great deal of work to be done, so how will you continue to move this forward, and what will you do to ensure that progress continues at an acceptable rate?

[137] **Edwina Hart:** I have to say that we have to quicken the pace on this. It is important that we keep up the pressure. So, each local health board will generate action plans, through the chief executive, by December 2009. There will be a self-assessment exercise, against the annual operating framework in each LHB in January 2010. The intelligent targets will have an impact in 2010-11. Clinical and executive champions will have been appointed in those seven LHBs, and we will be able to use them to get the appropriate feedback and to keep the pressure on the organisations. So, hopefully, that mixture of measures will quicken the pace.

[138] **Irene James:** And put the pressure on.

[139] **Edwina Hart:** Yes.

[140] **Darren Millar:** Thank you for that, Minister. I think that we have dealt with the next three questions, so we will move on to Lorraine Barrett's questions.

[141] **Lorraine Barrett:** The Stroke Alliance appears to be a network of clinicians, while other healthcare professionals have set up their own networks. It is suggested that other healthcare professionals and therapists feed into the alliance. How helpful would it be to have an example of good multidisciplinary working in an advisory capacity?

[142] **Edwina Hart:** If you would like me to, I will arrange for the current arrangements to be looked at. I do not think that there is any harm in looking at what exists and at whether we could improve it in future. I am more than happy for that work to be undertaken and to give the appropriate assurance to the committee.

[143] **Lorraine Barrett:** In England and Scotland, joint stroke and cardiac networks are working to bring support organisations together with patients and carers to improve services. Perhaps you could look at that, or perhaps you have already given it some consideration.

[144] **Edwina Hart:** It has already been looked at in the new planning system.

Darren Millar: That brings us to the end of this item, Minister. With Members' permission,

we will move straight on to our next item.

11.29 a.m.

Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol—Sesiwn Graffu Gyffredinol
The Minister for Health and Social Services—General Scrutiny Session

[145] **Darren Millar:** I understand that Paul Williams is staying with us for this item, but that John Palmer will be joining us. Is that correct?

[146] **Mr Dean:** I think that I am being John Palmer for this, if that is okay. [*Laughter*.]

11.30 a.m.

[147] **Darren Millar:** Simon Dean will stay with us; that is fine. We have received a paper from the Minister, which updates us on work in her department. If we may, we will go straight to questions. Minister, you have provided quite a long list of the legislation that is progressing at Westminster, which relates to fulfilling your 'One Wales' commitments. One issue is that, sometimes, there is not the capacity in this place to look at and scrutinise effectively what has taken place at Westminster and the impact that it might have here in Wales. That is a separate matter that is not really for you.

[148] What estimates has the Assembly Government made of the cost of implementing each piece of legislation that has been passed or is progressing, and what implications might there be for your budget, given the current financial constraints?

[149] **Edwina Hart:** This is an extremely difficult area. It would be nice to devolve more, but you always have to look at the cost implications of devolution and the impact that it has on your budget. In these difficult budgetary times, that is foremost in my mind. I may not be able to have what I would like, because I have to manage what I have and keep the money in front-line health services. Legislation costing goes through the Finance Committee and is well scrutinised, as that committee considers every aspect of it. All 'One Wales' legislation has been costed, and I have not approved anything without first having addressed the financial issues and their impact on my portfolio across the piece. I have asked Paul and the department to look at my legislation programme to ensure that the costs of legislation development and implementation are monitored, and they report directly back to my ministerial board. I have been doing that for a long time because I am conscious of the costs involved. The amount of time that officials spend undertaking this work also has an impact, because if they are doing that, they are not doing work developing the policies that I already have control over. So, it is quite a mixed bag. That is why I have included so much on legislation. I thought that the committee would be interested to learn of some of the dilemmas that arise from developing legislation and the cost implications.

[150] **Ann Jones:** As you know, I have a draft LCO going through, which aims to reduce the risk of serious injury and fire deaths by installing sprinklers in all new-build housing. That has to be a saving for your budget, yet I am not allowed to include any savings because I am not allowed to do a financial regulatory report; the Government has to do it. When the Government comes to do that, will you ensure that the fact that this would represent a saving to the national health service budget is included?

[151] **Edwina Hart:** The Welsh Assembly Government always looks innovatively at legislation that comes to us see what impact it might have on our budgets, including any adverse impacts. We are cognisant of that at Government level, and we also look at every

piece of legislation and how it impacts on us in the health department. We have always looked at what impact environmental legislation has on us and at what we need to do. The health service is committed to carbon reduction and to doing everything that we can on that, and we are always interested in the legislation that is going through. Ann is right, as you could look at money spent on improving fire safety as money well spent as it will lead to savings in the future. So, the point is well made.

[152] **Val Lloyd:** Minister, I have two questions, but there is a thread that links them, so I will give you the two at once, if you do not mind. You mention in your paper the likelihood that the health Bill currently passing through Parliament will ban tobacco vending machines. Can you clarify what the implications will be for Wales if that Bill is passed and what representations your officials are making in relation to it?

[153] You also mention that you are considering the possibility of amending the Smoke-free Premises etc. (Wales) Regulations 2007 to ban smoking near doors and windows on NHS premises, which I am sure we have all highlighted. What consideration have you given to directing NHS premises to create smoking shelters for their staff so that they do not have to smoke under hospital canopies and in public bus shelters? It also affects grieving relatives.

[154] **Edwina Hart:** Whenever I visit a certain hospital—and I will not name it—I always find it quite amazing that, to get into the maternity unit, I have to walk through a cloud of smoke. I think ‘What on earth is going on?’, given that we have all these rules and regulations in place. I am actively considering amending the smoke-free premises regulations, as it would fit in with our other intervention support, such as hospital car parking, telephones and all those types of issues. We have not come to any firm conclusions on this but we can certainly consider the point that you make about staff and grieving relatives. Some of the local health boards are already looking at some of these issues, and Paul might be able to update you on that.

[155] I am quite supportive of the provision on banning tobacco vending, from a public health perspective. My officials are doing further work with Department of Health officials on that, but I do not have any further information on where we are with it. It is quite a low-level discussion at the moment, but I think that most people would agree that banning tobacco vending machines is the right way forward. We have done such a good job on the issues regarding tobacco advertising, smoke-free premises and so on that this is just the next natural step.

[156] **Mr Williams:** I remember introducing smoking shelters before the smoking ban, and they were helpful at that time. However, once the ban came in, we discussed the matter on my board, and we defined ‘premises’ as including the curtilage of the building, so no smoking was allowed on the entire premises, including the grounds. These things are difficult to police, but, as ambassadors for health, we have a responsibility to convince people of the wisdom of not smoking. So, my view is that we should continue not to allow smoking on the grounds of facilities.

[157] **Edwina Hart:** Val makes a good point about grieving relatives, however. It is not just about staff.

[158] **Mr Williams:** That is a longer term issue about how you encourage people not to smoke. It is difficult, and we often get issues of confrontation when staff challenge people, and so on. There probably is not an easy answer to this, but if we are to be firm about the damage that smoking does, we need to give some clear messages.

[159] **Darren Millar:** Andrew, did you want to come in?

[160] **Andrew R.T. Davies:** On that specific point, I am familiar with the Princess of Wales Hospital, which I believe was one of the original hospitals to ban smoking on its premises. I can never recall an occasion when I visited that hospital and saw people smoking on the pavement by the road. When I visit, they are smoking by the doors, in the courtyards—all over the place. So, what you have just told us is—

[161] **Mr Williams:** Staff were not allowed to smoke. We clearly indicated to the general public that it was not allowed, but people refused to recognise that. There were situations in which staff were asking members of the public to desist, which caused problems. The issue is that there must be a clear message from the health service that smoking is not a good thing to do.

[162] **Andrew R.T. Davies:** We understand the message, but it is just not happening, is it?

[163] **Mr Williams:** That is what I am saying. It is difficult in practice, so what do you do? The issue is whether you accommodate it.

[164] **Edwina Hart:** We have to be realistic about a lot of things in life. We have had the law on wearing seat belts for a long time, and some people still do not accept that they have to wear a seat belt when driving. We have laws on drink driving, but there are some people who still drink and drive. Whatever we do, some people will still say, in effect, 'Up yours, I'm going to smoke here even if you don't think I should'. We have to recognise that. The NHS is so adversely affected by smoking, given its health consequences, the cost of treatment and so on that we have to take a principled decision on this and state what the position of the NHS is. However, we have to recognise that there will be abuse, and that it is the poor staff who will have to deal with it and who get a mouthful. The majority of the citizens of Wales adhere to rules and regulations such as this one because they respect other people. The trouble is that we have a substantial number of people who do not respect other people and their wishes.

[165] **Darren Millar:** There is also the issue of hospital-acquired infections, which people acquire when wandering offsite.

[166] **Edwina Hart:** Exactly.

[167] **Darren Millar:** At my local hospital, Ysbyty Glan Clwyd, it is awful to see people puffing away around the entrance. It stinks, and you have to walk through all that to get into the hospital. Is that the point that you wanted to raise, Ann?

[168] **Ann Jones:** Yes, on hospital-acquired infections. I was not going to name it, as I was just going to say 'a hospital', but Darren has just mentioned it: Ysbyty Glan Clwyd. I have seen patients coming out of the entrance to smoke while still attached to a drip and then going back onto the ward. They could pick up an infection outside and then go back in. It is difficult for the nursing staff to deal with that.

[169] The other point that I wanted to bring up relates to car parking, which you mentioned, Minister. As you will know, our famous hospital, Ysbyty Glan Clwyd, has just entered into a lengthy and costly contract. Have you made any moves with the trust to reduce the cost of parking? People have free car parking in other hospital car parks, but people who visit Glan Clwyd or the University Hospital of Wales do not. Can you look at that?

[170] **Edwina Hart:** You might be interested to know that the new chief executive of Hywel Dda NHS Trust has reopened the issue of car parking charges in his local health board. He is looking at that again to see whether he can make improvements. I am sure that the chief executive of NHS Wales will be delighted to pass that information on to the chief executives of the NHS bodies in Wales, to see whether they wish to do the same.

[171] **Darren Millar:** Thank you for taking that question, Minister. Mrs Jones very cleverly moved off the theme, but we—

11.40 a.m.

[172] **Ann Jones:** I know how to get my questions in, Chair.

[173] **Peter Black:** I want to refer to the NHS reorganisation. You are on record, Minister, as stating that there are no redundancies and, in particular, that all senior managers, executives, directors and executive board members employed by the former NHS trusts and local health boards remain employed in the NHS either in new roles or engaged in meaningful work while organisational structures are being developed. Yet, when you go back to look through the planning papers and consultation papers for that restructuring, the original consultation paper envisaged that there would be redundancy costs of between £5 million and £14 million. In your oral statement to Plenary in July 2008, you referred to expectations of reductions in transaction costs demonstrated by reduced management and premises costs in those areas. There was a freedom of information request on the Assembly Government website in which a note to Ann Lloyd envisaged a reduction in executives, with an estimated overall cost of £13.5 million. The transition board draft management control plan reports that you stated that some of the aims of this restructuring would be to reduce transaction costs and improve the management of NHS services, which would be demonstrated by reduced management costs, but that, at that stage, you were unable to quantify those potential savings. Clearly, in terms of the planning of this reorganisation, the Government took the view that there would be redundancies, bringing forward savings that could be reinvested in front-line services. I am puzzled as to why that policy changed and how those envisaged redundancy costs disappeared into the ether.

[174] **Edwina Hart:** I have always made it quite clear to committee that it has never been my wish to make people redundant from the NHS. I would hate to see anyone losing their job; I wanted to lose things through natural wastage. However, I have always included the caveat, which sometimes gripes with highly paid executives, that we may not be able to put them in the appropriate position. I believe that we are doing exceptionally well, in terms of the first and second tier, in finding them suitable employment within the new structures of the NHS. However, I will ask the chief executive to comment, because this is very much an operational matter.

[175] **Mr Williams:** It is my understanding that, during the general debate about how the reorganisation would unfold, some rough costings were done with regard to the prospect of redundancies. That is all they were, because the Minister had a clear policy that there would be no redundancies.

[176] The next point that we need to look at is that the reorganisation was primarily about the way in which we would move from the ending of the internal market to a system of planning and collaboration. Reducing management costs was not the key objective. However, we recognise, as you quite rightly say, that one of the things that is bound to happen when you take out the internal market is a reduction in transaction costs. If you look at the old local health boards, there are at least 100 senior people involved in those. When I came into the Assembly, I said that we needed to secure a freeze on management, so that, as we take opportunities with redeployment, we can start to harvest these transaction costs. I also asked the former director of finance to set a baseline. We are now starting to measure the removal of those costs through natural wastage, because we do not have a redundancy policy. As we said the other day, in another setting, if we employed a redundancy policy, we would probably be talking about defending the prospect of spending £20 million making people redundant. So, there are issues here about the effective use of resources and the way in which we are going to

track this over time to see those savings taken out, because we have a freeze. That money will be moved to front-line services.

[177] **Peter Black:** If you said from the outset that there would be no redundancies, why was it built into all the consultation and the assumptions as part of the planning of the reorganisation, and why were savings identified for redundancies?

[178] **Mr Williams:** When I took over, there was no planning for redundancies. I was aware that people had looked at costs on a 'what if?' basis.

[179] **Peter Black:** The freedom of information request that is on the Assembly Government's website clearly says that there has been planning. Back in April 2008, there were estimated figures for redundancy costs of between £5 million and £14 million.

[180] **Mr Williams:** They were just assumptions.

[181] **Peter Black:** Assumptions, planning—

[182] **Mr Williams:** No, officials plan according to all sorts of assumptions and Ministers take decisions.

[183] **Peter Black:** However, you have just said that there was a clear policy from the outset. So, why were they making assumptions that were contrary to the Minister's policy?

[184] **Edwina Hart:** The way that Government works is that you receive advice from officials that it is wise, sometimes, to look at some of the issues that might be associated with redundancy in the long run if you cannot place people. That is just giving the advice that might be required, looking at various assumptions. However, I made a policy decision that I did not like the idea or the discussion on redundancies, because it was affecting front-line staff.

[185] When you talk about redundancy in the NHS, people are always worried that it will affect cleaners, porters, doctors, nurses and therapists. I wanted to make it quite clear, particularly to the trade unions and employees, that that was not our intention with any aspect of the reorganisation of the NHS. We recognise that, in management, there would be jobs that would be difficult. People have contractual rights in the NHS to leave at certain management levels and certain grades and to take packages. So, this was simply a forward planning exercise.

[186] These LHB changes have been very successful. They have only been in place since 1 October. Staff and professional organisations are quite happy with them and everyone is pleased that the Tory ethos of the market has disappeared from the NHS in Wales, which is a good thing. Picking around the bones of this in relation to something that has been quite successful is not particularly helpful to anyone. We have to look at the forward direction of travel and how, in the long run, we will be able to make savings to put into front-line services and how we are starting to streamline management positions within the LHBs.

[187] **Peter Black:** However, Minister, I am not referring to advice to you from officials; this is a consultation paper that you issued in your name in April 2008, in which you said that you had estimated figures for redundancy costs at between £5 million and £14 million. It is not about officials advising and you rejecting that advice; this is a paper that you issued that is in the public domain. How did that change when you stated at the outset that you were considering redundancy costs?

[188] **Edwina Hart:** I have explained it to my satisfaction, Chair.

[189] **Peter Black:** You have not explained it to my satisfaction. You are saying that your policy is to have no redundancies, and yet you issued a consultation paper with estimated costs for redundancy.

[190] **Edwina Hart:** The proof is that there have been no redundancies and that is all that staff in the NHS need to know. That is where they are. Officials were looking at possibilities and what might spring out as a result of concentration and those figures were put in. However, we are where we are, and I am not going back on any—

[191] **Peter Black:** The point of this questioning is not that I want redundancies, because I do not. However, there has been a reorganisation of the NHS and all of the papers that were issued on that and the various advice that has been given envisaged that there would be clear savings that could then be reinvested in front-line services. That reorganisation has taken place and yet we have no handle at all on what sort of savings have been achieved. We are left with the impression that we have a number of surplus managers who are still being reallocated, and we do not know whether resources will be released from that that could be reinvested in the front line. The issue here is whether we are getting an efficient service or top-heavy management that is costing us a lot of money that could be spent on front-line services.

[192] **Edwina Hart:** The issue is about what is happening now as a result of reorganisation, and we are doing a lot of work on this particular area, are we not, Paul? I would be more than happy, in due course, to share a paper with the committee about what has happened in the LHBs, what has happened with management positions, whether anyone has gone out on current contractual arrangements and how it fits into a pattern. However, we must recognise that these organisations were only established on 1 October and interviews are still going on within management grades. If the committee would like that information in due course when there is a further scrutiny session, I would be more than happy to provide the information that Peter is seeking to get at, so that we can complete the picture of the NHS reorganisation.

[193] **Darren Millar:** We would be happy to receive that. I would like to raise a point for clarification. Figures have been suggested in the consultation of about £14 million for redundancy; during the budget scrutiny session a few weeks ago, a figure of £20 million for redundancy was suggested. Why would you bother looking at the figures again, given that, from day one, the policy has been one of no redundancies? However, you have obviously looked at that again.

11.50 a.m.

[194] **Mr Williams:** Forgive me, Chair, but I did so in anticipation of that possible question and for no other reason. We have had a successful reorganisation, partly because we work in partnership with the trade unions. We negotiated an organisational change framework and people have worked hard with the confidence of not having redundancy hanging over them or not being faced with the threat of losing their jobs. We also need to think about losing corporate memory. There are issues here of people who have been working in the health service and of how we can redeploy them within structures. However, what is also clear, as I said in my first response to this, is that significant transaction costs will be removed as a result of an unnecessary internal market process. We set up a baseline to measure those.

[195] **Darren Millar:** So, it was not that you were reconsidering the no-redundancy policy.

[196] **Mr Williams:** No, I did so merely to furnish the committee with as much information as I could.

[197] **Andrew R.T. Davies:** On that point, accepting your explanation of that scenario and the fact that you did not want redundancies, you say that nurses and front-line staff are happy with the reorganisation. I appreciate that the reorganisation is only a month old—and I think that 37 or 38 organisations have been reduced to 10—but when I speak to people, it is clear that they are having difficulty understanding the fact that the structures have moved en masse from the management side—

[198] **Mr Williams:** No, they have not.

[199] **Andrew R.T. Davies:** That was the evidence given to the Finance Committee by the finance directors. Accepting that there were no redundancies and the assimilation that is going on, the finance directors also said that we need all hands to make reorganisation work. So, they are indicating that they need all of the administrative staff who have moved from the many organisations of the past to these single organisations. When do you envisage the assimilation taking its full course and having a clearer picture of whether the management structures of these new bodies are meeting their obligations?

[200] **Edwina Hart:** It cannot be true that everyone is doing the same, can it?

[201] **Andrew R.T. Davies:** I did not indicate that.

[202] **Edwina Hart:** Let us be frank: an LHB has only one finance director and only one director of personnel. So, we are already seeing staff reductions in that top team. There will be fallout from that, because people will not have got those jobs. We are trying to ascertain whether there are genuine and available jobs in the system to be undertaken and we are looking at the structures.

[203] In the long term, there are bound to be cost savings in management. Things have not happened wholesale everywhere, because some of these organisations are still working through these management issues. They have dealt with tier 1 and are now on to tier 2; they will move on to tier 3. This is a massive change in the NHS. I set the date for 1 October, but the process is ongoing. The point is that this process of reform—getting rid of the market, streamlining patient pathways and starting to deliver properly on what we need to do in health—has been welcomed. We should not take our eye off the ball. I now have to work with those new structures and the staff have to work together within them. Following this restructuring, despite that fact that the management process in the new LHBs has been quite difficult, management has proved to be up to the mark in dealing with some of these very difficult issues.

[204] **Andrew R.T. Davies:** So, it was not a case of your not wanting the £20 million against the reorganisation cost.

[205] **Edwina Hart:** We talk figures all the time; we look at eventualities and things that might happen. Things change daily and from month to month. I would not have thought, when I started these reforms as Minister for Health and Social Services, that we would be faced with an economic crisis—with the run on the banks and all of the money going into those—and I would not have known the impact that that would have on me. That simply came about. Advice from officials changes as do the daily implications for the service. That is the nature of Government advice—you try to consider all the inevitabilities and hope that you have covered them all.

[206] I have been honest with this committee. We have talked to you about each inevitability and we have been honest in consultation by talking about those inevitabilities. The tenor of this discussion indicates that I perhaps should not be so open and transparent and that I should just provide a nice, bland paper that says absolutely nothing so that I can be questioned on

that. However, that is not my style.

[207] **Darren Millar:** Okay, we will move on from this subject because time is against us. Dai Lloyd has some questions on organ donation.

[208] **David Lloyd:** First, given that we have wandered off the paper slightly, before we completely forget about tobacco, I want us to consider the importance of developing an anti-tobacco strategy in Wales, following the other countries in these islands. I am not only talking about banning vending machines, but about making cigarettes less freely available because the average age for starting to smoke in Wales is still 11 and therefore it remains very easy for 11-year-olds to get cigarettes here. I think that we need to get up and running with a comprehensive anti-tobacco strategy.

[209] Part of this paper has to do with organ donation and transplant. As you will be aware, I am a long-term advocate of presumed consent, which is not my favourite term, or of having to opt out of donation rather than the current situation where we all have to opt in—all 27 per cent of us, despite several very successful advertising campaigns. What is the latest situation on swapping the system around from the present opt-in system to a situation where, if you do not want your organs transplanted, you opt out?

[210] **Edwina Hart:** I have asked officials to come forward with advice on legislation.

[211] **Darren Millar:** You have made a decision recently on neuroscience. The work in north Wales as a result of the recommendations has been under way for some time. What is the timetable for the implementation of the recommendations?

[212] **Edwina Hart:** In north Wales?

[213] **Darren Millar:** Yes.

[214] **Edwina Hart:** They are getting on with the work as we speak, but I will check with my regional director about what timescales might be put in place. It is quite difficult because there are a lot of new services being put in place in north Wales and the new jobs have to be advertised. I will check on that to have a definitive answer on when it is going to the board for discussion, and I will respond to you with a proper timetable.

[215] **Darren Millar:** I would appreciate that. I think that there is—

[216] **Peter Black:** Can we have a timetable?

[217] **Edwina Hart:** Yes, I am happy to provide that.

[218] **David Lloyd:** Further to that, I am not going to reopen the debate about neurosurgery in south Wales as we are where we are; however, the option that we have in place of acute neurosurgery in Cardiff was not my favourite option and the Minister will be aware of that. The patient experience is all important now. If all patients with acute intracranial traumas are to end up in Cardiff, it is not just about the experience of patients from south-west Wales and Swansea, but also the experience of GPs because GPs admit people in an emergency to neurosurgery units and that has usually been—up until now—to the neurosurgery unit at Morriston Hospital. Obviously, there is a fair amount of interest out there in monitoring how acute admissions from south-west Wales and Swansea will be dealt with now, if they are all going to Cardiff. In terms of monitoring this and asking for timescales and action plans and so on, we also want some certainty as regards the patient experience, the experience of GPs when referring acute cases and the experience of getting a patient into an acute neurosurgical bed when required. How can we complete the scrutiny of that experience as a committee?

[219] **Edwina Hart:** We are where we are in terms of neurosurgery and I, like you, might not necessarily be that content. I have taken a decision and I think that I have taken the right decision on the basis of the advice that I have received from clinicians on this matter, and it is now a workable model. It is only the complex intracranial neurosurgery that will be undertaken exclusively at the University Hospital of Wales and I think that we have to recognise, in terms of the patient experience, that more patients from west Wales will now be treated for a whole range of issues in Swansea and they will not have to go as far as Cardiff. On the wider issues, particularly with regard to north Wales, there has been a very satisfactory resolution with additional services provided across the piece and recognition of the Walton issues. We certainly have all the clinical groups looking at this and the recommendations will be implemented. I will take up the points that you made with them and send a note to committee.

[220] **Ann Jones:** I wanted to talk about investment and capital investment in north Wales. There has been significant investment in Ysbyty Glan Clwyd and in the west end of Rhyl with the new primary healthcare centre—it is a super doctors' surgery basically. The issue of a new build at Ysbyty Glan Clwyd is still very much a sore point. The negative responses are coming from the local authority and from some areas within health, but not all of them. There is also an issue about what we can do about community facilities, given the poor fabric of the buildings that we are working in at both Prestatyn and Rhyl. Could you just give me an update on that? I do not mind if it is a note to committee. Could you give me some information about the new build at Ysbyty Glan Clwyd and about what we can expect in terms of community facilities from your capital investment programme?

12.00 p.m.

[221] **Edwina Hart:** The Glan Clwyd site is a difficult issue. It has been assessed as being fit for the service, but substantial work is needed on it. They have to look at all the issues to do with what service delivery they will offer in Glan Clwyd, and they will have to look at the building too. The building is the same as the one at Merthyr, of course, and you will have seen the substantial work and redevelopment that has taken place there, with bits being taken down, bits put in, and bits done. The same approach will be taken in Glan Clwyd. I am amazed that we are hearing this nonsense that this work will not be undertaken in Glan Clwyd. The chief executive and I have been discussing this matter and we have made it clear to the LHB. If there are other minds and mouths in the LHB, then those minds and mouths are better closed because the decision has been made to develop Glan Clwyd and there can be no going back to some of what they might have wanted to do historically in north Wales, which led us into a most difficult position on services. We had the farce prior to 2007 about what would happen in Llandudno, and we have had all these rows about Glan Clwyd.

[222] We are trying to put substantial investment in across the piece, and when I look at my forward work programme for investment, Glan Clwyd is included in terms of the capital that will be provided. If there are any changes, such as a change of Government, for instance, and not necessarily at Westminster, I could not make any guarantees about the type of investment that might go into north Wales, but that is not going to happen, of course, so I can therefore be assured that I can use the capital that is available in my forward work plan for Glan Clwyd.

[223] If Members are interested, I am more than happy to provide a note to the committee on where I see future investment going in light of the plans that I already have in the department.

[224] **Ann Jones:** Can I just ask you about the community services and the state of some NHS buildings, such the Royal Alexandra Hospital in Rhyl, which now has problems because of fire code issues? Although we accept that the fire codes are those for the NHS—people have noted the fact that the North Wales Fire and Rescue Service has not been in and done it,

but I realise that the trust has its own fire code, which we have to agree to—at the bottom of all this is the safety of patients, and we have to ensure that. It is about community facilities, too, however, at Prestatyn and Rhyl. Can we see anything coming forward from your capital investment fund to assist the trust in putting in some fantastic community services in Rhyl and Prestatyn?

[225] **Edwina Hart:** I have sent Dr Chris Jones, the chair of another health board, to look at the situation regarding some of the community services in north Wales. Quite a large trickle of correspondence has started to reach me concerning what is alleged to be happening with the local health board and some of the statements that have been made, particularly those about Prestatyn and the use of these community hospitals.

[226] Dr Chris Jones has a role in looking at primary and community healthcare, and we have to see what facilities we have, how we can utilise them better, and if we cannot utilise them, we must ask what other public purpose they can be used for. He is having discussions across the piece with representatives of the communities up there and the other concerned groups to see how we can make better use of the facilities. We have some lovely facilities, such as those at Pretastyn, and neighbouring land. What is required there? Should there be health centres there? Where is the best location for them? If health services are not utilised, should there be a clinic facility for out-patients? Should I be looking at housing, sheltered accommodation for people with learning difficulties and other disabilities perhaps? Those are the types of things being considered. Chris Jones is having an initial stab at it, and he is visiting that area. He will be reporting back to me.

[227] I can assure you that if any money is available, then we can always help projects, especially the small projects, with a couple of million pounds. We will do that from the budgets that we have. I have to make it clear, however, that we are not taking the same approach as before of closing services without the communities understanding where services will be. Communities have to understand that where changes are made, it is for the better, and they need to understand what that change for the better is before well-loved facilities are taken away.

[228] **Irene James:** I would like to talk about hospital waiting times. I can see that you are—well, we will not go into that. Waiting times is an issue that people outside often see as being the whole ethos and picture of the NHS. We have a target from referral to treatment of 26 weeks. How confident are you that we are achieving that target? How sustainable will that target be? What investment has been allocated for this year and in future budgets to deal with that issue?

[229] In addition how is patient choice built into that 26 weeks? Someone might be due to go into hospital from referral to treatment, and they say ‘No, I cannot come in because I want to go on holiday’. How often is that added into the choice, or does that aggravate targets?

[230] **Edwina Hart:** You raise a very important point because people may be offered an operation on their knee or hip, and they think twice about whether they want it done. Sometimes, they will take a lot longer to say ‘Do I really want to go through that; can I manage the pain better?’, and that is where the whole issue of tolerance comes in with targets. In the past, perhaps we have been far too rigid in telling people that they should have the operation, and so on.

[231] The targets for 2009 are for 100 per cent of patients to be seen within 26 weeks from the date of their referral to the start of treatment. However, we allow for clinically complex conditions and some patient choice exceptions, which illustrates that tolerances have been introduced. So, the tolerances state that 95 per cent of admitted patients and 98 per cent of non-admitted patients should be seen within 26 weeks, and that the maximum waiting time

for patients should be 36 weeks. The latest data for closed pathways relating to August 2009 shows that during the month, 92 per cent of admitted patients and 96.3 per cent of non-admitted patients had their pathways closed within 26 weeks. This compares with 91.3 per cent and 89.9 per cent at the end of July 2009, so there is progress. Unvalidated data for September 2009 is available for those patients on an open pathway, and shows on an all-Wales level that 5.7 per cent of patients on open pathways were waiting over 26 weeks, compared with 7.6 per cent of patients at the end of August, so there is progress there. In addition, 2.1 per cent of patients were waiting for over 36 weeks, compared with 3.5 per cent of patients at the end of August, so there is also progress there.

[232] As I am speaking about targets, it might be helpful if I move on to the performance of accident and emergency departments. The latest figures for September 2009 show that 92.1 per cent of patients were admitted, transferred or discharged within four hours, and that 99 per cent of patients were admitted, transferred or discharged within eight hours. Two hospitals achieved the four-hour target of 95 per cent, and eight hospitals achieved the eight-hour target of 99 per cent of patients being admitted, transferred or discharged within the timescales.

[233] On the ambulance service performance, the figures for the end of September show that performance against the eight-minute response target time of 65 per cent across Wales as a whole was 67 per cent. Four out of the seven new LHBs covered the 60 per cent target, and 17 out of the 22 unitary authorities achieved the target. Handover data for September, which are the first to be recorded electronically, show that performance across Wales was 77 per cent. This compares with 80 per cent for August 2009, when data were recorded manually, but we have more faith in the new data collection systems. The latest performance data for September 2009 show that the number of patients delayed was 495, which amounted to 32,154 days, which sounds enormous. However, since September 2003, the number of delays has dropped by 56 per cent and the number of days delayed has reduced by 71 per cent.

[234] So, there is progress on the overall agenda—the issue is sustainability. There is no point in having a target of 26 weeks at December 2009 if hospitals go back to their old habits in terms of slippage after they have achieved it. So, the issue for us is the sustainability of that target. I am hopeful that this will be achieved unless anything further happens with swine flu. Swine flu could intervene on some of the issues around targets, and we all accept that when you have a pandemic, it could impact on many matters.

[235] I am generally pleased that the ambulance service performance is moving in the right direction, but I must be certain in my own mind, before I say ‘Well done’, that this is sustainable for the service and I do not yet have that assurance in my mind to be able to give it to you.

[236] **Irene James:** To follow on from that, I am very pleased with what you said about the sustainability of the 26-week target. However, in other areas of the UK, they have brought the target down even lower than 26 weeks. Are there any plans to go along that line? Following on from that, what are the target times to reduce waiting times for specific specialities such as cardiac and cancer patients?

12.10 p.m.

[237] **Mr Williams:** We have no plans to go below the 26-week target, but the vast majority of cases are well within the 26 week target, and the general feedback that we are having shows that people are content with that timeframe. The important thing is where we put in the flexibility of extending the period for people who want choice, we have ensured that it is an absolute maximum of 36 weeks, whereas, in England, it falls away. We have a tougher fallback situation, or absolute, of 36 weeks, which we are managing rigorously, because when we put in that flexibility, we did not want it to be abused or gained from. The target is to get

everybody through within 26 weeks. If, however, as I mentioned, there are issues of choice, we need to build flexibility in. So we are saying that that is fine, but the absolute maximum is 36 weeks. We are more rigorous in that respect than some other UK health systems.

[238] On the issue of sustainability, there is a worry about a possible increase in demand. We cannot legislate for swine flu, but the issue that we are now pursuing with the local health boards is how effective they have been in managing their resources and in ensuring that what they run is being run productively, or whether it could be done in different ways. What we saw—again, it came through in the evidence of the finance directors—was the old behaviour of bidding up the problem, rather than managing the resource that we have and redesigning services. That is a challenge for every healthcare system, not just the Welsh system, because we all have to live within budgets and we all have to live according to more exacting standards. So, there is a lot of work to do on sustainability, but my greatest effort is not about asking for more money; it is about whether I can be satisfied that what we are using has been used effectively, whether we are using it in an intelligent way and using alternative ways of treating patients in care pathways. There is lots of work to do here.

[239] **Edwina Hart:** Simon, do you want to quickly talk about the cardiac issues, because there have been problems with cardiac waiting times?

[240] **Mr Dean:** There have been and there are some difficulties. For example, perfusionists are a shortage group of specialised staff. Colleagues in the NHS are working incredibly hard to improve performance and I am pleased to report that we are seeing an improvement.

[241] **Edwina Hart:** There is a recruitment issue there, which is also being dealt with in Cardiff and the Vale NHS Trust now, which is impacting upon cardiac services. Yesterday, I had a discussion with Jane Hanson and my professional advisers about the cancer targets. We will be looking at the cancer targets, and I will make some further announcements about developments in that area.

[242] **Irene James:** Do you have any idea of when those announcements will be made?

[243] **Edwina Hart:** I had the meeting yesterday, I expect to have a note of the meeting today and then I expect to be able to tell you something.

[244] **Irene James:** As quickly as that? That is wonderful.

[245] **Edwina Hart:** I hope that the people who took the note are listening.

[246] **Ann Jones:** They will be panicking now. [*Laughter*.]

[247] **Andrew R.T. Davies:** Before I move on to a couple of other questions that I want to ask you, Minister, on targets, one of the key things is the level of breaches of the targets. How are they being managed, given that 31 December is the date when we will know whether the targets have been met or not? There is a suspicion that some LHBs have had higher breach rates than they should have had. How is the Welsh Assembly Government, in particular you and your officials, working to manage the breaches and the—maybe ‘abuse’ is too strong a word—use of breaches?

[248] **Edwina Hart:** We had some problems at the end of last year, which we have resolved, in relation to one of the organisations that now forms a LHB and is quite close to this particular building. Do you want to comment on the action that we are now taking, Simon?

[249] **Mr Dean:** The word that springs to mind is ‘rigorously’. Colleagues are working on a day-to-day basis with organisations to ensure that they have plans in place to deliver the

service that the target requires, that they are doing so appropriately, and that we are not having any data-recording difficulties. I can categorically say that all organisations are focused on achieving the target for the right reasons and in the right way.

[250] **Mr Williams:** The other thing is that I have introduced a greater intensity. There is now a weekly report, so if there are difficulties or if we have numbers that are starting to run away, we know on a weekly basis, rather than waiting a month, and then we have more time to recover the situation.

[251] **Andrew R.T. Davies:** That weekly reporting was not something that was happening previously, was it?

[252] **Mr Williams:** No. It was a monthly tracking. I want to get more intensity in the system so that we can manage it. It is much easier now with seven organisations.

[253] **Edwina Hart:** We also have to say that they have standard advice on how they deal with their waiting lists and times, but there is no novelty in how they might be dealing with patients, ringing them up and asking them whether they still want to be on lists. We have a common approach now across the piece to make sure that we have genuine figures to consider.

[254] **Andrew R.T. Davies:** Bearing in mind that we have known about the target for Access 2009 of 31 December, the evidence received in the Finance Committee was that, of the 24 targets, that was one of the two on which they would be spending a lot of time in order to meet to them. We have touched on sustainability, and I will refer to another example, of access to wheelchair services. I visited the centre in Wrexham, and the staff there said that money was put in to hit the target, but when the money dried up—because it was a one-off payment—they would go back to the old ways.

[255] **Edwina Hart:** No, they are not.

[256] **Andrew R.T. Davies:** You are correcting the manager of the centre, then, because she told me that the money had dried up, and they could not sustain the service. Those were her words, not mine. On the sustainability model, how confident are you, given the evidence that we have on the financial burden that many local health boards now face to clear deficits, some of which are quite dramatic? For one that is close to home, as you put it, £60 million has to be cleared by 31 March. How do you think that that might impact on the ability to keep to a wait of under 26 weeks from referral to treatment?

[257] **Edwina Hart:** We believe that it is sustainable within the budgets that they have, providing that they are working through the system properly. That is why I said in answer to a question, ‘Are we looking at anything further now at this stage?’, that we are not. We are looking at getting to the 26 weeks, and managing the 26 weeks as sustainable through the whole national health service. When we go out and about and meet people, and when I go out and about as an Assembly Member, I have exactly the same thing being said to me in relation to other Ministers’ portfolios: ‘We can’t manage with the budget that we have had from such and such Minister’. There is always that opportunity, when you are out there. When I was in employment, we would be asked, ‘Do you think that you have enough staff in the department?’ Of course, the answer to that question is always ‘no’, is it not? If you are managing a group of staff, it is human nature to say, ‘No, we don’t have enough resources’. We think that the money that we put into services is sustainable across the piece. It is just that everyone wants a little more. It is easier to have a lot more cash to play with, rather than using your brain to think laterally about how you can better develop services within the—

[258] **Andrew R.T. Davies:** I take the point that you have made. You made it in a rather

condescending way—

[259] **Edwina Hart:** No.

[260] **Andrew R.T. Davies:** A point was put to me in relation to maternity leave, for example. When someone went on maternity leave, there was no resource to put someone in that person's place; so they were going from nine members of staff to seven members of staff. You can say it however you want but the fact of the matter is that if you do not have the resource to provide that additional resource, you do not provide the service that gives the patient the experience that you want.

[261] **Edwina Hart:** It shows that you are not managing your service or your staff properly. You are paid to manage and put those people in place. That is what we pay people their wages for. It is managed in other sectors, and I have seen it managed in other sectors. I have no time for this if they are not managing the service properly. Staff should not be penalised to work harder because a colleague is off on maternity leave. It is not as if you decide today to have a baby and you have it tomorrow; there are quite a few months to plan how the maternity leave will be covered. Many of the issues that you raise are actually issues of management and about looking at the long term. If someone says, 'I'm off on maternity leave next April and I'm telling you now', it is a matter for you to look at how you manage the service. That is not what has been happening sometimes within the national health service. It is too easy to say, 'If I had extra money I could do this or that'. It is not a question of extra money; it is a question of making your resources cover those front-line jobs and doing so effectively and efficiently.

[262] **Andrew R.T. Davies:** I am sure that many managers will read with interest what you have said, Minister, and most probably will look in exasperation in the mirror.

[263] The one point that I would take from what you have said is that the budgets that have been allocated will make this figure sustainable.

[264] **Edwina Hart:** Yes.

[265] **Andrew R.T. Davies:** Irrespective of going on from 31 December we should not be lapsing, once that date has passed, on the financial settlements that you have given them to date.

[266] **Edwina Hart:** We would hope not.

[267] **Andrew R.T. Davies:** You said that, so you will be held to account for that.

[268] I will raise two other points with you, Minister, the first being on the old chestnut of ambulances. In discussing stroke services over the last hour we touched upon them and on the important role that ambulances play in conveying patients and ensuring the speedy administration of treatment. There have been various comments from your coalition partners about giving consideration to breaking up the ambulance trust.

12.20 p.m.

[269] You have touched on the improvements today, and we have seen that from the figures; you have announced investment, particularly in vehicle location kits so that operators can see exactly where the ambulances are, and that is a very welcome investment. However, there is a mixed message coming from the governing parties. One party is saying that we should break up the ambulance service and you, as Minister, are making the final decision. Could you give us an indication of what your views are going forward, so that people in the ambulance trust

may have confidence in where they will be in 12 to 18 months' time? Their future obviously depends on the delivery of service, and we all subscribe to that, but what is your view?

[270] **Edwina Hart:** There is no divide and rule on this agenda. We are two separate political parties, and will have different policy views about the direction of travel. However, as a Government we have the 'One Wales' agreement, which governs the direction of travel for us, particularly in our health policy, and there is no mention of anything to do with a major reform of the ambulance trust within that agreement. However, I welcome the debate and the points raised by Helen Mary Jones, as health spokesperson for Plaid Cymru, because it gives me the opportunity to look at the wider issues around this. The LHBs, of course, will be taking control of some of the funding issues around the ambulance trust from 1 April, and we will see what improvements arise from that.

[271] There has been a long-running saga of me trying to produce, for all of you, the patient transport paper, which I had hoped to produce a long time ago. However, as Win Griffiths and others went into the issues around patient transport in more depth, they found more and more issues that they felt had to be resolved, and which I had to report on publicly. I very much hope that we are coming to the end of that now, and I must say that, in terms of patient transport, part of the problem in producing the plan was that we did not have the appropriate engagement from the ambulance trust, which one would have thought, at managerial level, would have been interested in the discussion on patient travel. We have now had this engagement, as we come to the final stages of publication and looking at the issue.

[272] All of those issues are in the melting pot. I am delighted to see the improvement, but, like you, I want to see sustainable improvement across Wales. I want the ambulance trust to operate in all parts of Wales rather like it currently does in north Wales, where there is a fine example, even though there are hiccups, of a very well-managed service. The service was very conscious of its responsibility to patients, and seems to have a good relationship with communities. It works really well, and I have been very impressed by the way that it has done that, and it is in direct comparison to what goes on in south-east Wales. In Torfaen, for example, which is full of dual carriageways and has plenty of access arrangements, the figures are still of major concern and we have had to put resources in.

[273] In answer to your question, I think that Helen Mary has introduced a very interesting flavour—

[274] **Andrew R.T. Davies:** But it is not currently on the agenda for the Government, because it is not in the 'One Wales' agreement.

[275] **Edwina Hart:** It is not in the 'One Wales' agreement, and it is therefore not a Government policy. However, that does not mean that it will not emerge in discussions over the next 12 months, if people continue to have concerns about the way that the ambulance trust is run and managed.

[276] **Peter Black:** May I come in on that point? You talked about the access roads in south-east Wales, and, you are right, there are some very good access roads there, but my understanding is that most of the ambulances are queuing outside accident and emergency departments in south-east Wales, as in fact they were in north Wales over the summer when I visited. So, that issue also needs to be resolved.

[277] **Edwina Hart:** We are seeing massive improvements in handover, and we have seen specific improvements within the Royal Gwent Hospital. We have had a management regime change within the whole structure in the Aneurin Bevan Local Health Board, which has definitely led to specific improvements. We have given it additional cash to improve the way that it accesses patients in and out, because the Royal Gwent is not a very nice place in terms

of visiting patients in the accident and emergency department. There is definitive improvement coming along, and I have emphasised, particularly to the new local health boards and the old trust, that they are responsible for ensuring that the ambulance service meets its targets by getting patients through the system. So, if that carries on, I think that we will definitely see that working much better. We have focused, not only on the Royal Gwent, as you indicated, but also on Morriston Hospital, where there have been enormous problems. There have also been enormous problems in Cardiff, at the Heath hospital, and in north Wales. The reason why I mentioned the north Wales service is because, in general, it has quite limited problems compared with the problems elsewhere. Paul, do you want to talk about its performance?

[278] **Darren Millar:** I remind Members and witnesses about the time.

[279] **Peter Black:** I just want to follow up on that, because there is also an issue about the occupancy rates of acute beds, and whether those beds are available to move patients on from accident and emergency departments. That seems to be an issue around most of Wales now, and I wonder whether that is being addressed as well.

[280] **Mr Williams:** It is has been a particular problem at the Royal Gwent Hospital. I was there the other day, and lengths of stay are about a day and a half longer than is the case in accordance with best practice elsewhere in Wales. That is partly because of the bed management system; a paper-based system is still used, and I have spoken to the chief executive and his team about ways to improve that.

[281] **Andrew R.T. Davies:** I want to touch briefly on nurse prescribers. I received an answer from you, Minister, that information on the number of nurse prescribers is not held centrally. That troubled me, because there is a 'One Wales' commitment to increase that number. How does the Government monitor the development of nurse prescribers within the service? Linking that to school nurses, there is a 'One Wales' commitment in that area, but there is grave concern about your ability to achieve that commitment given progress to date.

[282] **Edwina Hart:** The commitment on school nurses will be dealt with. We have had successful discussions with the professional bodies concerned, and there have been some marvellous consultation responses. We have a steering group taking all the issues forward, and I can tell you that we are on track to complete on time.

[283] **Andrew R.T. Davies:** By 2011?

[284] **Edwina Hart:** Yes, we are definitely on target. We have had to take things day by day, and we have taken the profession with us, and I am delighted with the programme. I am extremely keen on independent nurse prescribers, and we have funded two supplementary training courses—conversion courses—and we are certainly getting staff through the system. Nurse prescribers are the way forward in many areas. We do not keep the information centrally, but the LHBs will be aware of the numbers if you wish to obtain them.

[285] **Andrew R.T. Davies:** Why do you not keep them centrally? It is your aspiration as a Government to have more nurse prescribers, so how do you know how many are on the ground? I appreciate that the LHBs would know.

[286] **Edwina Hart:** I can ask them.

[287] **Andrew R.T. Davies:** As a Minister, should you not have these figures readily available?

[288] **Edwina Hart:** There is a lot of information that you might like to have at various

times, but it is a question of having the right information when you are making decisions. I have supported the policy, we have put the courses together, and the service is being used. The service is not for me, up in Cathays Park. I am quite satisfied with the existing arrangements because I can get the information when I need it or if any problems arise. I have a lot of requests for information that is not held centrally—Health Solution Wales sometimes holds information, as do various other bodies. I wonder if there is a job to do—I look to the chief executive here—in deciding definitively what information we need to keep centrally. Perhaps there should be a review. The situation has just developed historically—there is not necessarily any rhyme or reason to some of this.

[289] **Darren Millar:** We will have to move on to Lorraine Barrett's question.

[290] **Lorraine Barrett:** I have tried not to butt in too much, but other Members have asked a lot of questions and I am left with two minutes, but that is okay. Could the Minister give us an update on wellbeing centres and pharmacy-based NHS drop-in centres? You talked about improving the checks on blood pressure for stroke, and so on, and obviously it is easier for patients to drop in somewhere in the high street. Can you give us an idea of where the wellbeing centres are, and how many you hope to have established by the end of the third Assembly? I would also like to pick up on something that Paul said. He talked about one of the hospitals keeping patients in longer than it should, and there was an item on the radio the other day about a scheme that has been trialled whereby patients, on admission to hospital, have a card put on their—

[291] **Mr Williams:** That was Cardiff and the Vale Orthopaedic Centre at Llandough Hospital.

[292] **Lorraine Barrett:** Was it Llandough? I thought it was a brilliant idea, because the patient can focus on getting out by a certain date. I wondered if that was something that could be—

[293] **Mr Williams:** I have asked the chief nursing officer and her counterparts throughout the principality to ensure that that good practice is spread. It is an excellent idea, and I have seen it for myself—everyone is focused on the day of discharge.

[294] **Edwina Hart:** On the drop-in centres that you referred to, negotiations on land acquisition to start two wellbeing centres are well advanced. One is for Merthyr healthcare park, for which I am waiting for the business plan and which I hope to have in November 2009. Cardiff Royal Infirmary is the other location for a wellbeing centre. This is good news, and they will be up and running as pilots.

[295] In addition, we have met pharmacists to discuss more work for the pharmacies as drop-in centres. We are still in discussions with Pharmacy Wales, and, in fact, I had a discussion with it earlier this week.

12.30 p.m.

[296] **Lorraine Barrett:** Could we have an update as the project progresses? I would be interested to see how it interacts with GP surgeries. Obviously, we do not want duplication, and information needs to be shared.

[297] **Edwina Hart:** Yes, I am happy to do that.

[298] **Darren Millar:** I have one final question. We have received a copy of a letter regarding merit payments, which was sent by Helen Eadie MSP to the Prime Minister and you. May I ask for your comments on the letter regarding the potential scrapping of merit

payments, which, apparently, are costing £30 million in Scotland? The principal reason for not scrapping them is that they are paid everywhere else in the UK and that it could therefore result in a disadvantage in recruitment terms.

[299] **Edwina Hart:** I was quite interested when I received the letter from the MSP. It is my intention to speak with the Scottish and Northern Ireland Ministers for health to discuss their views on this. However, I understand that Nicola Sturgeon, the Scottish Cabinet Secretary for Health and Wellbeing, wrote an article for a newspaper saying that she quite liked the system. I was quite concerned about something that was brought in such a long time ago being kept in the consultants' contract, and I wonder whether it is still relevant. The chief executive is looking at those issues for me before I engage in discussion with the other Ministers for health.

[300] **Darren Millar:** Thank you. With that, we will have to close the meeting. I thank Simon Dean, the Minister and Paul Williams for their attendance at the committee today. I remind Members that there is no meeting of the committee next week. However, we will be launching our sunbed report on 11 November at 10.30 a.m. Our next committee meeting will be on 18 November, when we will commence our review of wheelchair services.

Daeth y cyfarfod i ben am 12.31 p.m.
The meeting ended at 12.31 p.m.