Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

The National Assembly for Wales
The Health and Social Services Committee

Dydd Mercher, 24 Mai 2006
Thursday, 24 May 2006

Cynnwys
Contents

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

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

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

Swyddogion yn bresennol: Mandy Collins, Cyfarwyddwr Ymchwiliadau, Arolygiaeth Gofal Iechyd Cymru; Steve Elliot, Pennaeth Cyllid, Gofal yr Ysbyty; Dr Peter Higson, Prif Weithredwr, Arolygiaeth Gofal Iechyd Cymru; Dr Tony Jewell, Prif Swyddog Meddygol; Amanda Jones, y Tîm Gofal Cymdeithasol; Angela Jones, Cyfarwyddwr Arolygiadau, Arolygiaeth Gofal Iechyd Cymru; Rosemary Kennedy, Prif Swyddog Nyrsio; Elizabeth Lockwood, y Gyfarwyddiaeth Polisi Pobl Hyn a Gofal Hirdymor; Stuart Marples, yr Adran Iechyd a Gwasanaethau Cymdeithasol; Steve Milsom, Dirprwy Gyfarwyddwr, y Gyfarwyddiaeth Polisi Pobl Hyn a Gofal Hirdymor; Ian Stead, Cyfarwyddwr Dros Dro Adnoddau Dynol, NHS Cymru.

Eraill yn bresennol: Tina Donnelly, Cyfarwyddwr, Coleg Brenhinol y Nyrsys Cymru; Richard Jones, Dirprwy Gyfarwyddwr, Coleg Brenhinol y Nyrsys Cymru; Gareth Phillips, Cyngor Coleg Brenhinol y Nyrsys Cymru; Lisa Turnbull, Cynghorydd Polisi, Coleg Brenhinol y Nyrsys Cymru.

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

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

Officials in attendance: Mandy Collins, Director of Investigation, Healthcare Inspectorate Wales; Steve Elliot, Head of Finance, Hospital Care; Dr Peter Higson, Chief Executive, Healthcare Inspectorate Wales; Dr Tony Jewell, Chief Medical Officer; Amanda Jones, Social Care Team; Angela Jones, Director of Inspections, Healthcare Inspectorate Wales; Rosemary Kennedy, Chief Nursing Officer; Elizabeth Lockwood, Older People and Long Term Care Policy Directorate; Stuart Marples, Department of Health and Social Services; Steve Milsom, Deputy Director, Older People and Long Term Care Policy Directorate; Ian Stead, Acting Human Resources Director, NHS Wales.

Others in attendance: Tina Donnelly, Director, Royal College of Nursing Wales; Richard Jones, Deputy Director, Royal College of Nursing Wales; Gareth Phillips, Royal College of Nursing Wales Council; Lisa Turnbull, Policy Adviser, Royal College of Nursing Wales.

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

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

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

[1] **Rhodri Glyn Thomas:** Bore da, a chroeso cynnes i'r cyfarfod hwn o'r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol. Yn groes i rai sylwadau a glywyd dros y penwythnos, fe'ch sicrhaf nad oes neb yn gwastraffu amser yn y pwyllgor hwn, a'n bod yn craffu yn fanwl ar y Gweinidog.

Rhodri Glyn Thomas: Good morning, and a warm welcome to this meeting of the Health and Social Services Committee. Contrary to some comments made over the weekend, I assure you that no-one wastes time in this committee, and that there is detailed scrutiny of the Minister.

[2] **The Minister for Health and Social Services (Brian Gibbons):** Who said that?

[3] **Rhodri Glyn Thomas:** Nid oes gennyf syniad, Weinidog, ond yr oeddwn yn deall bod rhyw sylwadau wedi'u gwneud.

Rhodri Glyn Thomas: I have no idea, Minister, but I understood that some comments had been made.

[4] Fe'ch atgoffaf o'r angen i ddiffodd unrhyw offer technegol—nid yw'n ddigonol eu bod wedi'u gosod i ganu'n dawel. Atgoffaf y rhai sydd yn yr oriel gyhoeddus fod offer cyfieithu ar gael, sydd hefyd yn caniatáu i'r sain gael ei glywed. Felly, os ydych yn cael trafferth clywed yr hyn sy'n cael ei ddweud yn y pwyllgor, byddwch yn gallu clywed yn glir drwy ddefnyddio'r offer cyfieithu.

I remind you that you need to switch off any technical equipment—it is not sufficient just to leave it on silent mode. I remind those in the public gallery that translation equipment is available, and that it can also be used for amplification. So, if you have difficulty in hearing proceedings, you will be able to hear clearly via the translation equipment.

[5] Deallaf fod ychydig o broblemau gyda'r offer technegol, felly sicrhewch fod y golau coch ar y microffon yn dangos yn glir cyn i chi lefaru; arhoswch cyn mynegi unrhyw beth tan fod y golau coch hwnnw ymlaen, er mwyn sicrhau bod y cofnod yn llawn.

I understand that there are a few problems with the technical equipment, so ensure that the red light is on the microphone before you speak; wait for that red light to appear before you make your contribution, so that we can have a full record of the meeting.

[6] Os oes angen inni symud o'r ystafell, ac o'r oriel, dilynwch gyfarwyddiadau'r tywysyddion.

Should we need to evacuate the room, and the gallery, follow the instructions given by the ushers.

[7] Croesawaf Dr Dai Lloyd yn ôl i'r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol; yr ydym yn falch o gael ei gwmni. Mae'n eilydd ar ran Helen Mary Jones.

I welcome Dr Dai Lloyd back to the Health and Social Services Committee; we are pleased to see him. He is substituting on behalf of Helen Mary Jones.

[8] **Karen Sinclair:** May I pass on Lynne Neagle's apologies?

[9] **Rhodri Glyn Thomas:** Iawn.

Rhodri Glyn Thomas: Fine

9.33 a.m.

Adroddiad Blynyddol Arolygiaeth Gofal Iechyd Cymru
Annual Report of the Healthcare Inspectorate Wales

[10] **Rhodri Glyn Thomas:** Yr ydym yn falch fod prif weithredwr Arolygiaeth Gofal Iechyd Cymru, Dr Peter Higson, gyda ni, yn ogystal â Mandy Collins ac Angela Jones. A oes gennych unrhyw sylwadau agoriadol, Dr Higson?

Rhodri Glyn Thomas: We are pleased to be joined by the chief executive of Healthcare Inspectorate Wales, Dr Peter Higson, as well as by Mandy Collins and Angela Jones. Do you have any opening comments, Dr Higson?

[11] **Dr Higson:** Thank you for the opportunity to present our first annual report, which covers 2004-05. The first report deals with the setting up of HIW, and some of the issues around that, as well as the initial part of our inspection programme. Our next annual report will be published in September or October, and that will carry much more detail about the work that we have undertaken in rolling out the programme at the end of 2004-05 and 2005-06.

[12] **Rhodri Glyn Thomas:** Yr ydym yn edrych ar y cyfnod ers sefydlu'r arolygiaeth, a'i blwyddyn weithredu gyntaf. Mae cyfle yn awr i aelodau'r pwyllgor wneud sylwadau neu ofyn cwestiynau.

Rhodri Glyn Thomas: We are looking at the period since the inception of the inspectorate, and its first year of operation. There is an opportunity now for committee members to make comments or ask questions.

[13] **David Lloyd:** Members will appreciate that I am new to this committee, so I pray your indulgence, as it were.

[14] We all welcome the creation of Healthcare Inspectorate Wales. I am trying to get a handle on exactly how you fit into the greater scheme of things. We are, obviously, aware of the Care Standards Inspectorate for Wales and allied bodies, and of the work that has been done by other committees with regard to streamlining and co-ordinating regulation and inspection regimes. My first question is: how do you see yourself fitting in, not only into the part of regulation and inspection with regard to healthcare premises and patients, but into the overall umbrella of needing the whole regulation and inspection regime to be streamlined?

[15] I was also trying to get a handle on how you impinge on the patient experience. How would patients recognise that somewhere is being inspected, or has been inspected? Put simply, what sort of things do you do? Is there an assessment of the costings in this report? I realise that this is a new organisation, but I would like confirmation of the set-up costs and revenue costs. We have gone through a number of structural details, but how do you expect this to pan out in terms of the patient experience? If you discover something such as unacceptable MRSA rates, how do you expect to influence a turnaround in such adverse infection figures? How confident are you that any recommendations that you put before a health body in terms of, for example, MRSA—I use this as an example as there is evidence to suggest that high turnover, restricted numbers of beds, lots of patients in the same bed in a short space of time, and cramped spaces, along with the whole hospital cleanliness experience has an input into MRSA levels—would be accepted? How forceful could you be in any recommendations to rectify this situation?

[16] **Dr Higson:** There are a number of issues there, and I may ask my colleagues to pick up one or two in due course. Would it be helpful if I just covered the background to HIW and the statutory base, leading into your questions about how we fit into not only health, but the wider regulation field?

[17] We were set up by the Assembly as a result of the Health and Social Care (Community Health and Standards) Act 2003, which, in England, set up the Healthcare Commission, which is legally known as the Commission for Healthcare Audit and Inspection. We both replaced the former Commission for Health Improvement, which was abolished and replaced under that legislation. We share the same legislative base as the Healthcare Commission, and, under the Act, we have a duty to collaborate with it. The key area of responsibility for us is to ensure that we inspect NHS-funded care in Wales. So, we look at the commissioning of care, the provision of care, the commissioning of care in England for Welsh patients and, as I said, have a duty of collaboration with the Healthcare Commission.

[18] In doing so, there are five key areas that we need to pay regard to according to the legislation: patient access to healthcare, the quality and effectiveness of healthcare, its management, economy and efficiency, the information given to patients and the public about health services and about their care, and the rights and welfare of children. Some of the legislation was a result of the Bristol inquiry and its aftermath with regard to some of the issues around consent and children's services generally. That is the broad legislative base.

[19] As with the Healthcare Commission, we have a duty to inspect and investigate NHS-funded care, either on a routine basis to provide public assurance about those issues or to act specifically if areas of concern are brought to our attention, by whatever route, about systemic problems with an area of healthcare. However, the key area is to give public assurance, and that includes a number of other players and organisations.

9.40 a.m.

[20] In May last year, the Assembly published a concordat between the bodies that regulate, audit and inspect healthcare and health services, with commitments to streamlining the process of regulation. Subsequently last year, Healthcare Inspectorate Wales was given the lead on the health strand of that work, and, later this year, we will bring about a number of significant changes in collaboration with the others. So, we will include people like the Wales Audit Office, the Health and Safety Executive and so on, to ensure that the whole regime of the regulation and inspection of the health service is more proportionate, efficient and focused, and that it looks at what counts and what matters to patients and the public generally. That will involve working with the others to share information and to plan our work, so that we are not falling over each other, and to rely on each other's findings, so that we do not have to do everything afresh all the time. We are enthusiastic about the fact that, although we are new, we will have a key and pivotal role in ensuring that the whole landscape of regulation and inspection will look different and will be of better value in terms of what it produces.

[21] That is also part of the wider regulation review, and we await with interest the outcome of the Beecham review, which we believe will say something about that, and we will fit in and implement any recommendations made by Beecham accordingly. However, we feel that, in health, we are probably ahead of the game in doing this, in that we already picked this up with the department 18 months ago, and are now taking the lead in trying to ensure that we reduce the overall unnecessary burden. There is a balance that we must strike between what the public requires and needs in terms of assurance and the process that the NHS must go through, which, sometimes, can be not terribly efficient, and not as focused and biting as it should be in terms of external review.

[22] I will defer in a minute to Angela—this is a warning for her—to talk about the patient experience work that we are doing at the moment and how that will develop, and then to Mandy Collins to pick up the issue about MRSA and the intention to do some spot checks around hospital acquired infections in the coming year. I will just pick up the point about costings. The overall budget for HIW is about £1.8 million, which is not dissimilar to the amount by which the Assembly sponsored the former Commission for Health Improvement. We have grown slightly this year, by taking on new responsibilities. There are no additional costs to the Assembly, but we took on some of the responsibilities of Health Professions Wales around the local supervisory authorities for midwives, and around some of the quality assurance for nurse education. We have also had a transfer from the Care Standards Inspectorate for Wales to pick up private and voluntary healthcare in Wales. So, we are now equivalent to England, in that we look at healthcare across both sectors, not just the NHS, and we can assure that an equivalent process of review and equivalent standards are applied to all sectors.

[23] I now defer to Angela Jones to pick up the patient experience.

[24] **Ms Jones:** In terms of our routine programme for inspections, we actively encourage patients and the public to provide us with information and to contribute to the information and evidence that we take about the work of the organisation and the services. We put out press notices in the local press; all our information is provided in English and Welsh, across the board. We also put notices up in the organisations or use the organisations' websites in order to alert the local area that we are looking at these services in the hospital or community, and are around and about. We also formally issue bilingual letters to community bodies, voluntary sector organisations and community health councils in the area, inviting them to comment on services. Through that process, we will then meet with individuals who may have a particular point to raise, organisations, voluntary organisations and community health councils, should they request it, or receive written information, or, if they ring in, we can log and formally record that as part of our process. So, we encourage and actively seek the views of local people.

[25] The other thing that we may take forward is reports being available for interpretation. We have provided reports on an audio basis, on request, in order to ensure that we provide the information in the format that people want and that is useful to them. We have our own website with a facility for people to send in information interactively, which is logged and monitored to ensure that we keep up to date with what comes through. So, we can all receive information in that way.

[26] In the inspection process, we construct a team to help us to assess the organisation, and it may look at particular areas. Two key areas that we look at in all our inspections are public involvement and the patient experience. In the team that we construct, we include perhaps four or six individuals—members of the public and professionals from either England or Wales. We have used people from Scotland and Northern Ireland on occasion, to give an external view. We do therefore involve members of the public in our inspection activities.

[27] When we interview staff or read documents and assess them, part of that process includes members of the public who have been trained to work with us on our approach to routine work. We are also developing work with, and have involved, organisations such as MIND and Mencap, in order to bring user and public views into the inspections, when we are considering a particular area. We provide support and assistance for those people, in line with MIND and Mencap recommendations, to help them to contribute fully to our inspection.

[28] Our reports are published widely and are formally issued across the community. Anyone who contacts us, be it a member of the public or an organisation, is automatically sent a copy of the report on publication, so that they receive feedback on that work. Our reports are produced in various formats so that anyone who wants to read them finds them accessible. We will be moving to a shorter version of the report in order to improve readability. That has been a point that we have learnt over the last couple of years.

[29] **Ms Collins:** I will just pick up on the MRSA issue that you raised. On Peter's earlier point, I must say that we are very much a new organisation. We really want to focus on areas that are of concern to the public and to patients. Hence, in our programme for 2006-07, we have a series of eight spot checks on infection control. We are going to pilot this approach, and these visits will be unannounced. We will be going into organisations and picking up on how they prevent infections. We will be using these as short, focused reviews, where we want a quick turnaround in terms of timely reporting. We are developing the methodology with experts in the field and we really hope that it will start to impact on this area, which we know is of major concern to all.

[30] **Jonathan Morgan:** Before I get to the review programme for 2006-07, I will deal with the annual report. The paper from the Government states that the role of Healthcare Inspectorate Wales is to assess whether NHS bodies have effectively met, or can be judged against, national standards, agreements and clinical governance guidance, assessing management and the quality of the services provided across various agencies and sectors. I know that it has been rather limited in the first year or so, in terms of what you have been able to review. However, have you been able to learn of any particular problems that NHS bodies are facing, particularly in terms of meeting their clinical governance requirements, the national standards, and their obligations under the SAFF? Secondly, how rigorous are you in the light of your position as part of the Assembly Government? I accept what you say about the issue of independence and that you are not situated at Cathays park, although you do fall within one of the Government departments. How rigorous are you able to be in the light of the difference between you, as an organisation, and an organisation such as Estyn, for example? I know that they are two very different organisations, but does that difference have an impact on the way that you are able to operate?

9.50 a.m.

[31] Have you been able to form a view on the organisations that you have reviewed so far, in terms of their management structures? The only criticism that I have of the annual report is that while you tell us what you have been doing and achieved, you do not outline any particular issues that you have been able to flag up in the initial process of the review work that you have done. I accept that you publish individual reports, but, in terms of the culmination of your annual work, you have not been able to outline exactly what it is you have found. From that point of view, I did not find the report to be overly helpful. Did you discover any particular management structure problems or issues within the LHBs and trusts that you examined that gave you concerns about the way in which management boards are structured and whether they are efficient, offer value for money and are effective in delivering healthcare to improve the patient experience and so on? I did not see much of that in the report. I would be grateful if you were able to tease that out.

[32] **Dr Higson:** The initial annual report was quite difficult to write, because it is very much about setting up an organisation. We started our first review in November 2004 and published it in July 2005, so it would have been quite wrong to try to generalise on very limited evidence in the first annual report. I assure you that we will cover many of the areas that you mentioned in the second annual report, where we will have a sample of about 15 NHS organisations in Wales and a much safer base to draw out some of the themes.

[33] In terms of the early work, there are three areas where we do not have criticisms or problems, but they are areas of variability that we would want to discuss more in our second annual report. One area relates to access to healthcare. There are still issues that are publicly known relating to access to certain types of healthcare across Wales. Access to specialist healthcare varies, and we will say more about that in our second annual report. There is variability in public and patient involvement. That is not a criticism but a comment that there are examples of very good public involvement, but there are also examples where the public has not been as well involved in service configuration discussions, changes and consultation as it could have been.

[34] The other area that we will develop in the second annual report relates to commissioning arrangements, and it is widely accepted that they need to be reviewed and strengthened in Wales. More clarification about roles is also needed between local health boards, Health Commission Wales and the way in which networks operate. In the report that we published on the cancer networks, we highlighted the need for stronger governance arrangements within networks, which is particularly important given the vital role that they have in fulfilling some of the objectives of 'Designed for Life'; for them to be functioning and working is of great importance. Our view is that some of the governance issues should be dealt with early in the process of establishing networks, as we recommended in our review of the cancer networks. Those would be the broad themes so far.

[35] In terms of your point about management and organisations, we have not come across anything that would give us real cause for concern. Organisations in Wales are at different points of maturity, and that is clearly reflected in some of the arrangements that they have in place for matters such as clinical governance. Every organisation views clinical governance as a key area, and the area that probably needs further work is the way in which they integrate clinical governance into their broader governance processes and agenda. One can see the difference between trusts that have been established for many years and local health boards which are two to three years old. They are moving in that direction and will get there. However, there are differences due to the maturity of the two.

[36] In terms of our independence, Healthcare Inspectorate Wales has been established through delegations under the 2003 Act. So, the delegations come from Ministers to the Permanent Secretary, and then to the person in my post and to the staff, and they variously give us the right to publish without reference to anyone else, to schedule our own work programme, and to determine our own conclusions. Therefore, there is no interference with that process, given that the delegations are the statutory delegations, under the Act, to the post of chief executive. In a way, I feel that we have established a very strong independence in Wales; I am very comfortable with it, in terms of the relationships with other Government departments, and we have never had an issue or any contention with regard to discharging the powers that we have been given in terms of where we sit within the Welsh Assembly Government.

[37] **Jonathan Morgan:** I have just two points for clarification. As an organisation, are you able to consider reviewing a particular body without it being in your forward work programme or without it being raised with you by the Minister or by a particular department?

[38] **Dr Higson:** Yes.

[39] **Jonathan Morgan:** Therefore, if a particular issue arose, such as that which you identified for future examination, namely the way in which patients and the public are involved, and service reconfiguration—and, of course, there is a lot of that going on at the minute with 'Designed to Deliver'—potentially, you could have a whole range of complaints being brought to you stating that patients and the public have not been involved in the consultation on service reconfiguration, at which point are you as an organisation able to say, 'Well, there is an issue there, and, therefore, we will examine that'? Are there certain benchmarks? How do you assess such a situation?

[40] **Dr Higson:** About 10 separate issues have been referred to us in the first two years, and they have come from a variety of sources. I must say that only one has come from the Welsh Assembly Government specifically, which was about a medium secure unit report. All the others have come from members of the public or NHS bodies. We are increasingly getting requests from NHS organisations to come in and look at specific issues for them, in terms of their trying to resolve a particular matter or demonstrate transparency in their dealing of it.

[41] We are very careful that we do not tread on the ground of the ombudsman, of the complaints procedure, the police or professional bodies with regard to individual conduct. Our concern relates to where there are clear, systemic problems and failures, and where high-risk activity is being carried out in an NHS body, and so on. In considering any such request, we very thoroughly screen it and bring in outside expertise to advise us as to whether there is something that we should be looking at. Our very first request came from a member of the public, back in the summer of 2004, so, anybody is free to ask us to consider undertaking an investigation, and we have to demonstrate why we decide to do so, or not, in a very public and transparent way.

[42] **Rhodri Glyn Thomas:** Gwrandewais â diddordeb ar eich sylwadau ar yr adolygiad o rwydweithiau canser. Fel y gwyddoch, mae'r pwyllgor hwn yn bwriadu cynnal adolygiad o wasanaethau canser drwy Gymru. Ni wn os y bydd hyn yn bosibl, gan fod dau aelod arall o'r pwyllgor am ofyn cwestiynau ichi, ond os oes gennych sylwadau am y rhwydweithiau hynny a fyddai o ddefnydd i ni, neu awgrymiadau ynglyn â sut y dylem edrych arnynt, byddai'n ddefnyddiol pe gallech sôn amdanynt ar y diwedd.

Rhodri Glyn Thomas: I listened with interest to your remarks about the review of cancer networks. As you know, this committee intends to conduct a review of cancer services throughout Wales. I do not know whether this will be possible, as two other committee members wish to ask questions, but if you have any comments about those networks that would be helpful to us, or suggestions regarding how we should look at them, it would be useful if you could mention them at the end.

[43] **Jenny Randerson:** You have twice alluded to the other organisations involved in inspection and regulation; is there a need for further reorganisation of inspection? It sounds as if it is a bit of a crowded field to me. I realise that that is possibly a difficult question for you to answer, but do you anticipate the possibility of further reorganisation?

[44] I was reassured by your remarks about your independence, but I had underlined the following, which said that HIW,

'enjoys a certain level of independence and organisational safeguards to ensure no undue interference in its business and decision making'.

[45] Do you feel that your independence would be great enough, for example, when you have done a review of trusts or LHBs, to call for a reorganisation of them in specific cases? Do you feel that your remit goes that far?

[46] I have another couple of specific questions. In relation to NHS trusts and some of the reviews that you are planning, you refer to self-assessment. In education, it has been found that it takes a long time to build up reliability and expertise in self-assessment among those who are being assessed. It takes many years, through an inspection system, to build up that confidence and accuracy in self-assessment. I am, therefore, interested in the fact that you will be doing limited and focused fieldwork to corroborate self-assessment. Can you flesh that out and say how much limited and focused fieldwork there will be? Is it a day or a week's inspection or do you just pick specific bits to look at? I am particularly interested in that in relation to the Welsh Ambulance Trust, as your special review will be part of an ongoing process because of concerns in the past.

[47] I very much welcome the review of child and adolescent mental health services, and I hope that it will take place as soon as possible in the forthcoming year, because I am sure that you are aware that the Children's Commissioner for Wales has raised this matter and it has been raised here dozens of times.

[48] You are doing four unannounced infection control reviews. How will you select those four? Are you selecting them as top-of-the-range and bottom-of-the-range in terms of statistics, or are you just doing it in response to problems and so on? How are those being selected? Four is a very small sample out of the 22.

[49] In relation to the inspection of independent healthcare, you say that you will be doing inspections based on operational decisions. Will you be doing these inspections in response to potential problems? How far will your programme of inspection be based on potential problems or reasons for concern? There is more and more independent healthcare, as you point out, and people who use those services are entitled to a good standard in the same way that everyone else is. I am slightly concerned about considerations of confidentiality. How far will confidentiality impact on your reports on independent healthcare in a way that would not impact on your reports on the NHS? The reports need to be as honest and as full as those on NHS services.

[50] **Rhodri Glyn Thomas:** Yr oedd un neu ddau o gwestiynau yn y fan honno.

Rhodri Glyn Thomas: There were one or two questions there.

[51] **Jenny Randerson:** Sorry—but they were very specific ones.

[52] **Dr Higson:** I will ask Mandy Collins to pick up the questions on CAMHS and infection control in a minute. I will try to cover the areas that you mentioned; please remind me if I miss anything out.

[53] The first point about wider regulation is a policy matter for the Government and we will be part of any further changes that may occur. In the meantime, as I said earlier, there is, in the terms of the concordat between the bodies regulating health—those auditing and inspecting—a very strong desire to tidy things up and make inspection, as I say, much more focused on patients and on what matters, and much more based on risk. We have all come at this from different points of view, and the ambition is to come at it from one point of view so that we can work with, and rely on, each other.

[54] There is also the intersectoral aspect. How do we ensure that services are well provided and well regulated at interfaces between health and other agencies? That, again, is a key area on which we have done work with the Social Services Inspectorate for Wales in looking at it in terms of its joint review programme and our LHB programme. More of that will happen this year in terms of looking at the critical interface when patients move from one care sector to another, because that is frequently where governance fails: at the point of transfer.

[55] In summary, if there is a change in Government policy on regulation more widely, clearly, we will be part implementing that wider change. What I would say is that we are already some way towards streamlining what is going to happen in health in the future and, hopefully, that would be part of any Government policy and would be amalgamated into it.

[56] You also picked up the independence issue. There is a degree of it. The best way I can put this is to say that I believe that independence is about how you behave, how others behave towards you and the freedom that you are allowed to do the job that you have been asked to do. I can say, with all honesty, that we have been given that independence in the last two years, and that continues. One can argue that there is no such thing as truly independent bodies and that they are all accountable to someone for what they do in terms of their performance and their delivery. The fact that we sit within the Welsh Assembly Government has not compromised our ability to do this work in any way, and we have already, on occasion, commented on Assembly Government policy, especially around the medium secure unit report in terms of needing to revisit some of the work and look again at forensic psychiatry in Wales.

[57] I do not think that it is our place to comment on the structural reorganisation of the NHS; it is our place to look at the impact of structures on patient care, safety and the efficiency of the service generally. We can comment on it, but I do not think that it would be for us to make recommendations in that respect. However, if we felt that there were organisational matters that in any way impeded or adversely affected patient care, we would comment on them, but that is very much a Government matter and not a matter for HIW.

[58] We are in a transition year this year. We are going from the format of review that we started out with to a format that is based on self-assessment. You are quite right: self-assessment takes time to establish itself. We are working with the department very closely on this because, clearly, it is the department and the Government that wish to set the criteria that they want assessed in terms of the safety, quality and efficiency of NHS services, and they are all captured by the healthcare standards for Wales, which were published last May. Our job is to devise, in collaboration with the department, a robust method of capturing self-assessment and then testing it in a way by which we feel that we can give sufficient public assurance about what an NHS body is saying. So what we are looking at, in essence, is a period of two years, starting now, during which we move to self-assessment. We pick up with NHS organisations a methodology that will be doable for them, and which will require them to publicly declare their self-assessment. I feel that there is a very strong argument for that because it strengthens public accountability of the NHS. It is accountable in terms of finance, annual reports and other matters to make it more publicly visible in terms of quality and patient safety, and that is a key area where we can make a difference. So, we are looking at developing self-assessment next year and at having a year during which we gradually embed that.

[59] On your point about what work we will do in terms of assurance, we will be flexible on that. We will do enough to be able to give the assurance, and, if we find things or there is a poor self-declaration or self-assessment, we might do more work with those organisations to try to find out why that is the case and bottom-out what the issues are. So, the simplest way of answering that point is to say that the assurance work that we will do will be sufficient for us to give a robust public assurance about the standards, quality and safety of NHS care. It is a process that will take a couple of years to embed fully. However, it should lighten the burden felt by NHS bodies, while, at the same time, making them much more publicly and transparently accountable for those elements of their services.

10.10 a.m.

[60] I will ask Mandy Collins to come in on CAMHS and infection control, and then I will come back to your points on independent healthcare.

[61] **Ms Collins:** On CAMHS, a number of concerns have been brought to our attention over the last 18 months, and we have been working in collaboration with the children’s commissioner on one of those reviews. As a result of those issues, we feel that we need this full review of CAMHS, which will consider the availability of and access to CAMHS services in Wales and will link to the parallel review that we have been undertaking of child protection arrangements across NHS Wales.

[62] On scoping the approach and the areas of review, we will be setting up a steering committee and will be inviting colleagues from other inspectorates and policy areas, and from external agencies, to join us to help us to scope the review. It will be one of our first reviews in the new year. I hope that that assures you of the speed with which we will respond to this and the importance we attach to it.

[63] On your question on infection control and how we will focus those reviews, it is true to say that every routine review that we will do will look at infection control arrangements, but these will be very specific and focused reviews. For this first year, we will be using background information on infection control issues and untoward events, and some of the information that the National Public Safety Agency has recently published, to help us to focus on and decide where those organisations will be in year one. It is about public assurance and we need to focus on where there are problems.

[64] **Jenny Randerson:** Does that mean that you will be going to those trusts in which you feel there is a problem?

[65] **Ms Collins:** Yes.

[66] **Dr Higson:** On your point on independent healthcare, just to update the committee, there are currently 64 registered settings in Wales providing private and voluntary healthcare, which range from hospitals to dental clinics to clinics providing laser and intense pulse-light treatments. It is a growing sector, of which we need to be mindful. We have taken on that responsibility from the Care Standards Inspectorate for Wales this April after planning it for about a year. It brings a number of things into line. It gives us the opportunity to apply the same healthcare standards in due course across the public and private sectors. The intention is to begin that in 2007-08 and to fully implement it from 2008 onwards. Discussions with the sector lead me to say that it welcomes this. On your point about confidentiality and business issues, it is keen to seek a way around that in terms of being able to publicly report on performance against standards. At the moment, there are public reports on performance against care standards regulations, but there is a keenness to develop that and to have an equivalent regime in both the public and private sectors in Wales.

[67] **Karen Sinclair:** I want to take you back to something that you said at the beginning about your role in terms of access, quality and efficiency. What role can you play in ensuring equality of access to healthcare across trusts and LHBs? I am talking about postcode accessibility to particular health treatments. How much involvement have you had in this area of work so far—I am hoping that you are going to say that you do get involved in this—because it is relatively new? What sort of powers would you have if you were in that sort of situation? Are you into giving advice, or would you be into something stronger than recommendations?

[68] **Dr Higson:** I will preface my answer by saying that, by looking at specific organisational reviews, you generate a lot of knowledge about small bits. From next year, when we will be looking more across the board at healthcare standards, we will be able to draw out more general themes across Wales than we are currently able to. So, we can only partly answer your question at the moment, but we are going in that direction.

[69] We have picked up specific issues of access, which we have detailed in our reports and in our recommendations around organisational reviews. The powers that we have are to publish a report and to require an action plan to be prepared by the organisation concerned. In the action-planning process, we give the responsibility to the NHS body to develop it and to involve the partners, other stakeholders, and the public in that process. We then sign it off with the department and ourselves because, clearly, there could well be resource issues that need to be picked up as part of an action plan, which have to be cleared as possible and do-able.

[70] In terms of the point about the further powers that we have, I think that the relationship in Wales is different from that in England. The powers for the Healthcare Commission are very similar. However, in Wales, we have a very clear performance management and accountability regime. We have the kind of relationship with the department where our action plans, once we have all agreed them, can be incorporated into the accountability agreements and development plans of NHS bodies. We will then monitor the implementation of our recommendations, but we are also keen not to have a plethora of action plans lying around the place. So, once we have produced ours, we then pass it on to the regional office, which will pick it up and integrate it into the score card and the performance management. We will then keep an eye on that and, obviously, if there was a failure to implement a serious one, we would want to go back and find out why. The power is already there in terms of performance, and our power is to make public recommendations, agree them and then pass them on to the appropriate people.

[71] We are also working ever more closely with organisations such as the National Leadership and Innovation Agency for Healthcare and the delivery and support unit. We are sharing information, looking at what more longer-term development work might be indicated by some of the recommendations coming out of our reports. We also look, with NLIAH, at opportunities to showcase the good practice that we pick up. On that note, we are planning to run a joint conference in October to look at what local health boards have achieved in the first two to three years, and what themes have emerged from the modernisation assessments and the reports of local health boards.

[72] **Karen Sinclair:** Thank you for a very full answer. It could be quite a protracted process by the time that the reports are written. The recommendations go back to the regional office, which then works with the trust. What capacity do you have, if any, to actually react quickly? Quite often, it is speed that is of the essence with regard to people who are looking for care.

[73] **Dr Higson:** I think that, generally, the process that we carry out is longer than it needs to be. Part of what we have done since we have started is to try to review and shorten the timescale. If, at any stage during any piece of our work, an issue arose that we felt was particularly important, I would raise it with Mrs Lloyd during our monthly liaison meeting as an issue requiring more immediate action. We are absolutely committed to the idea that it is not the process of inspection that is important, but the outcome and the changes that it brings about. So, in whatever we do and however we develop over the next year or so, we will get things turned around quicker, and have a much richer description of what is going on in Wales in terms of themes and issues that are arising. However, even now, we will act immediately if there is something that we feel needs picking up.

[74] **Jonathan Morgan:** Just to go back to the issue of the format of the reviews, you have already stated that the use of self-assessment is important but there would be limited and focused field work to corroborate what has been said in the self-assessment. What form does that sort of field work take? I would imagine that there is probably a limited number of visits, but is it a case of mainly having meetings with the chief executive or the chair, or do you meet with a variety of different individuals—not just the officials of the trust, for example, but maybe people at the sharp end of healthcare delivery?

10.20 a.m.

[75] I got the impression reading it that it related more to having a cup of coffee in the trust office, as opposed to perhaps walking around the site and seeing where any particular pressures were. What is the form? It sounded rather like the mini-inspections that now take place in schools, where self-assessment is important, and the entire governing body participates in that. To what extent are other people, other than the most senior individuals in an organisation, involved in this process? I imagine that it could be extremely time-consuming if you reviewed every aspect of what was being done within a particular body, but you used the word ‘limited’, and I was wondering how much grasp you can have in terms of what you are looking to review within a particular organisation.

[76] **Dr Higson:** To be absolutely clear, we do not do self-assessment at present—that is something that we are moving towards. However, self-assessment will require organisations to put in corroborating evidence; they cannot just say, ‘We are good at this’, they must demonstrate why they say that. Therefore, the development of this whole approach will be underpinned by the organisations concerned having to demonstrate and provide the evidence to support what they say about themselves.

[77] That will give us the beginnings to work out what level of corroboration is needed. There will always be a minimum level, and you are right, we do not believe that that is about talking to the senior team alone—it is about looking for the impact and the benefits. If an organisation says, for example, that it has an excellent policy on nutrition and fluids, we would want to go and talk to nurses and patients, and ask them, ‘Does that work, do you get a choice of meals, do you get the right dietary things?’. Therefore, I am leaving it open as to how much corroborative work there is—limited focus does not mean that it is insufficient, it means that it will be proportionate, but that proportionality may change and shift according to what we find, and what the organisation tells us about itself.

[78] The other aspect that we need to do more on is how we have more systematic patient and public views on NHS organisations expressed. A lot is going on there, but we need to find ways of co-ordinating it. There is a lot going on within the NHS, as well as outside the NHS; we need to capture all that and get a more consolidated view of what patients and the public think about their local service.

[79] Therefore, I am not trying to not answer the question; I am saying that the amount of work that we need to do will vary, according to what we find, and according to what organisations tell us. However, we will do sufficient.

[80] **David Lloyd:** I commend the full answers that we have received so far. I want to flesh out what you said in answer to one of Karen's questions regarding your powers vis-à-vis your action plans. Take a hypothetical situation. You inspect across the independent and voluntary sector providers of care for NHS patients, and there could be an issue with limited or inadequate access, or the premises could be too small, or whatever, but it is outwith the ability of that provider to do anything about it in the immediate short term. There could be some long-term planning or resource issue—the provider could be a tenant and have no powers, effectively, to change this itself. What powers are contained in your action plan that would enable you to instruct someone, or what powers do you have to back up that issue when something needs doing, be it a planning issue, additional resourcing for access, or whatever? What sort of power is there behind your action plan recommendation?

[81] **Dr Higson:** We must be wary that we do not have the powers to dictate. We have the powers to recommend, and we have the powers to publish. Therefore, we can make public statements if we feel that there are areas of serious concern about patient safety, quality and so on—whether they are organisational resource issues, or whatever, we would say so. It would then be handed to the department to pick up, consider and act upon accordingly. Obviously, the power to publicly report is quite powerful, but one would hope that anything that we identify as crossing that line of being of serious concern and which could have a serious impact on the quality of service for, and the safety of, Welsh patients, would be picked up and dealt with by the department.

[82] **Karen Sinclair:** I have a quick question, to which you can hopefully just say 'yes'; I will be gutted if you cannot. When you carry out inspections, do you automatically refer to unions so that they feed back?

[83] **Dr Higson:** Yes.

[84] **Karen Sinclair:** Do you refer to all of the unions? In certain establishments, particularly in big trusts, there will be a number of unions. So, they are all contacted and asked for feedback?

[85] **Ms Jones:** Yes. As a matter of routine when we inspect an organisation, formal notification is sent out across the organisation. There are staff representatives at board level. We link locally, and we also link at a national level with organisations like the Royal College of Nursing and others. They are aware of our work, and can then bring matters to our attention at that level should they wish to do so. So, we do it locally in the organisation and will meet with any representative of a staff association who wanted to talk through any issues with us. We offer a number of avenues, both nationally and locally, for people to discuss issues with us on a one-to-one basis.

[86] **Rhodri Glyn Thomas:** Diolch. Yr ydym wedi cael mewnwelediad diddorol iawn i'r ffordd yr ydych yn gweithio. Yr ydym yn ddiolchgar am yr adroddiad ysgrifenedig ac am eich atebion llawn i'r cwestiynau. Hoffwn dynnu eich sylw yn ôl at eich adolygiad o rwydweithiau cancr. Bydd y ddogfen a'r argymhellion yn ddefnyddiol iawn i ni yn ein hadolygiad. Byddwn yn ddiolchgar am unrhyw awgrymiadau ynglyn â sut y dylem edrych ar y rhwydweithiau hynny. Mae'r pwyllgor eisoes wedi derbyn, yn ein sesiynau tystiolaeth, rai awgrymiadau a sylwadau gweddol feirniadol o berfformiad rhai o'r rhwydweithiau.

Rhodri Glyn Thomas: Thank you. We have had an interesting insight into the way in which you work. We are grateful for your written report and for your full responses to the questions. I would like to draw your attention back to your review of the cancer networks. The document and the recommendations will be very useful to us in our review. We would be grateful for any suggestions with regard to how we should look at those networks. The committee has already received, in our evidence sessions, some suggestions and critical comments with regard to the performance of some networks.

[87] **Dr Higson:** We have already been in discussion with the people doing this work for the committee in terms of feeding in what we have done in our review. We are at the stage where the cancer networks are preparing action plans to look at how they will respond to the recommendations. I will see if we can share drafts of those to inform the work of the committee. We have made recommendations, and I would rather wait and see what the response is and how people will take those forward. That may be a more constructive way of contributing to your work.

[88] **Rhodri Glyn Thomas:** Diolch; mae hynny yn ddefnyddiol iawn. Bydd cynnwys hynny yn arbed gwaith sylweddol i ni yn yr adolygiad. Yr wyf yn ddiolchgar iawn ichi am eich cydweithrediad a'ch parodrwydd i rannu'r fersiynau drafft o ymateb y rhwydweithiau i'ch argymhellion.

Rhodri Glyn Thomas: Thank you; that is very useful. Including that will save us a considerable amount of work in the review. I am very grateful to you for your co-operation and for your willingness to share the draft versions of the networks' response to your recommendations.

[89] Daw hynny â'r rhan hon o'r pwyllgor i ben.

That brings this part of the meeting to a close.

Gohiriwyd y cyfarfod rhwng 10.28 a.m. a 10.49 a.m.
The meeting adjourned between 10.28 a.m. and 10.49 a.m.

Coleg Brenhinol y Nyrsys—'Agenda ar gyfer Newid'
Royal College of Nursing—'Agenda for Change'

[90] **Rhodri Glyn Thomas:** Croeso yn ôl. Yr wyf yn ddiolchgar i Goleg Brenhinol y Nyrsys am ddod ar rybudd byr iawn. Yr oedd eitem arall i fod ar agenda'r wythnos hon, ond nid oedd modd ei chynnwys. Mae'r coleg wedi cyflwyno tystiolaeth ysgrifenedig, ac yr ydych wedi'i dderbyn y bore yma. Nid yw hynny'n fai ar y coleg nac arnom ninnau; y rhybudd byr a'r cyfyngiadau amser sy'n gyfrifol am hynny. Mae Aelodau wedi cael cyfle i ddarllen yr adroddiad.

Rhodri Glyn Thomas: Welcome back. I am grateful to the Royal College of Nursing for attending at very short notice. Another item was meant to be on the agenda this week, but could not be included. The college has presented written evidence, which you received this morning. That is not the college's fault nor is it our fault; it is the short notice and the time limitations that are to blame. Members have had time to read the report.

10.50 a.m.

[91] Gwahoddaf Tina Donnelly i roi cyflwyniad byr ar ran Coleg Brenhinol y Nyrsys, ac yna bydd cyfle i ofyn cwestiynau ac i wneud sylwadau.

I invite Tina Donnelly to give a brief presentation on behalf of the Royal College of Nursing, and there will then be an opportunity to ask questions and to make comment.

[92] Nodaf fod y dystiolaeth yn un persbectif ar 'Agenda ar gyfer Newid', o safbwynt y coleg. Gwahoddais y coleg am fy mod yn ymwybodol fod ganddo rai pryderon ynglyn â'r broses, er ei fod, fel pawb arall, yn croesawu 'Agenda ar gyfer Newid'.

I note that the evidence is one perspective on 'Agenda for Change', from the college's standpoint. I invited the college as I am aware that it has a few concerns about the process, although the college, like everybody else, welcomes 'Agenda for Change'.

[93] **Ms Donnelly:** The Royal College of Nursing is delighted to present the views of members with regard to the implementation of 'Agenda for Change'; they are not only the views of the college's staff, but also of its 23,000 members in Wales. We are also delighted that you have received the paper. I will highlight one or two issues that we included in the paper, which we feel are important and relevant to the committee.

[94] First, this was a new pay system that was first mooted in February 1999; talks on a national basis, involving the UK Government, on ‘Agenda for Change’ pay scales and pay framework concluded in November 2002. The original implementation date was 1 October 2004, but there was a renegotiation in Wales, meaning that implementation would be complete by 1 December 2004. However, given our close working relationship with Assembly officials and also within a partnership forum, we realised that, in order to have a robust and thorough job evaluation of the large workforce, we needed to renegotiate an agreeable timeframe. As a result, the implementation date was set for September 2005. We looked at that date and found that there was progress in job evaluation, but not so much in terms of the assimilation process—people being assimilated onto the pay scales and receiving money in their pay packets.

[95] An important element for the implementation of ‘Designed for Life’ is the NHS knowledge and skills framework, which is implicit in the reconfiguration of the health service agenda in Wales. Moving patients into the community is also important. We recognise the necessity for ‘Designed for Life’; the Royal College of Nursing has accepted and contributed towards that. Nevertheless, we have extreme concerns about the implementation of some of the initiatives contained within ‘Designed for Life’, such as the move from acute care into the community care framework if it is based on the knowledge and skills framework. Looking at ‘Agenda for Change’ implementation along with the current assimilation process, job matching and matching it with benefits realisation—on which we are happy to take questions—we have real concerns as to when ‘Agenda for Change’ will be completed in terms of this implementation.

[96] Another real concern to the college is whether or not it is fully funded. The college would like to pose two questions to the committee on that issue. What was the original funding envelope used for the implementation of ‘Agenda for Change’? How did it correlate with the funding advice from NHS trusts, as to how they saw the implementation of ‘Agenda for Change’? I have asked this question twice on behalf of the royal college at the NHS partnership forum, but I still have not had a response. What are the current estimates for the complete implementation of ‘Agenda for Change’ in terms of the financial package? Again the Royal College of Nursing is aware of the auditor general’s report, which demonstrated that the sum is between £24 million and £26 million. But, again, we are not clear whether that is the pay bill in relation to the 40 per cent of members of staff who have already been assimilated onto ‘Agenda for Change’, or whether that is the likely total bill. As we have not included the knowledge and skills framework and the potential need for training—and I am talking about nurses here—as a result of moving the acute care sector into the community sector, what will the real bill be in terms of implementation?

[97] We are also concerned that the knowledge and skills framework is not moving forward, particularly in relation to specialist nurse skills. Unfortunately, many of our members are reporting to us that trusts, in terms of the reconfiguration of services, are looking to flatten out—and those are the words used by staff—the clinical nurse specialist roles within clinical trusts. We have a problem with that, because, given the ‘Designed for Life’ criteria, nurse specialists have a key role to play in the implementation process, both in the acute care sector and in the community. We strongly believe that this must be a cost-cutting exercise. We have also seen jobs being frozen in terms of vacancies, and that, realistically, means jobs being lost to the NHS. We acknowledge that the Royal College of Nursing has received record funding for student nurse recruitment, to try to increase the numbers of nurses to 6,000, according to ‘Designed for Life’, I understand. However, we are hearing, in and around north Wales, that some student nurses are not being given substantive posts, and, therefore, they are not able to contribute to the knowledge and skills framework in order to deliver patient care, because they are being put on bank contracts. That means that they are working a minimum of, let us say, 4 hours per week up to a 35-hour week. It beggars belief that a newly qualified nurse must assimilate the knowledge and develop the necessary skills on that basis to care for patients, be that in the acute care sector or in the community. If we have trained these nurses, why are we not giving them full-time jobs? Why are we not linking to the Nursing and Midwifery Council’s recommendation that there should be an apprenticeship programme lasting for six months to a year, through which nurses would work alongside experienced nurses in order to gather those skills and to contribute to the knowledge and skills framework? So, we have real concerns over that.

[98] Recruitment and retention premia are another issue. We recognise that there has been record spending on bank and agency nurses, which realistically demonstrates to the Royal College of Nursing that there is still a nursing need. We are delighted that there is a developing nursing need, because we still have to provide bank and agency staff with the necessary acute care sector skills to care for patients who are still being looked after because of delayed transfers of care in hospitals.

[99] On the benefits realisation and the roles that nurses play within primary care, we are still concerned that, across the board, 'Agenda for Change' has not been implemented in primary care sectors. The Royal College of Nursing will be keen to discuss with the National Assembly the potential of local health boards directly employing practice nurses, as opposed to the situation with general practitioners. In terms of the benefits realisation, I will not negate the general medical services contract or the consultants' contract, because they are being paid for the work that they do, but we would like to see equity across the board in terms of the work that nurses currently do alongside, and often in absence of, their medical colleagues. If we are moving into the ethos of 'Designed for Life' and the principles that the Royal College of Nursing has accepted that there needs to be in Wales, we recognise that there will be funding deficits. However, realistically, until we have an absolute idea of what the total cost will be, and what the knowledge and skills framework will be in terms of the demands of the community care provision, we do not know where nursing is going in Wales, and that causes us great concern.

[100] **Rhodri Glyn Thomas:** Diolch yn fawr am y cyflwyniad; mae'n brofiad diddorol cael cyflwynwyr yn gofyn cwestiynau i'r pwyllgor. Nid yw hynny'n digwydd yn arferol. Gofynnwyd dau gwestiwn penodol, a thystiolaeth i'r pwyllgor yw hyn yn hytrach na thystiolaeth uniongyrchol i'r Gweinidog, er ei fod yn bresennol. Felly, atebaf y ddau gwestiwn hyd orau fy ngallu. Mae'r cwestiynau ynghylch cyllido wedi cael eu codi yn fynych yn y pwyllgor, a hefyd ar lawr y Siambr. Mae'n deg dweud mai ein dealltwriaeth ni ynghylch yr amlen gyllido yw y byddai 'Agenda ar gyfer Newid' yn cael ei gyllido'n llawn, y byddai hynny'n broses raddol, a bod trafodaethau rhwng Llywodraeth y Cynulliad a'r ymddiriedolaethau yn mynd yn eu blaen ar hyn o bryd, ond bod swm o arian wrth gefn ar gyfer wynebu cost 'Agenda ar gyfer Newid'. Dyna'r sefyllfa o ran y ddau gwestiwn am yr amlen gyllido a'r sefyllfa gyfredol, o ran ein dealltwriaeth ni, er fy mod yn derbyn nad ydynt yn atebion llawn.

Rhodri Glyn Thomas: Thank you for the presentation; it is an interesting experience to have presenters asking questions to the committee. That does not usually happen. Two specific questions were asked, and this is evidence to the committee rather than direct evidence to the Minister, although he is present. Therefore, I will answer both questions to the best of my ability. The questions about funding have often been raised in committee, and also in the Chamber. It is fair to say that our understanding of the funding envelope is that 'Agenda for Change' will be fully funded, that it will be gradual process, and that discussions between the Assembly Government and the trusts are continuing at the moment, but that there is a reserve sum to meet the cost of 'Agenda for Change'. That is the situation regarding the questions on the funding envelope and the current situation, according to our understanding, although I accept that they are not full answers.

[101] **Jenny Randerson:** Thank you for your evidence. I will ask some specific questions. Many of the issues that you have raised are general issues, which I and other committee members have raised on numerous occasions. You have provided a lot more detail behind that, which is very helpful in enabling us to really get to grips with the problem.

[102] In your evidence, you refer to the electronic staff record and the need for it to be in place before 'Agenda for Change' is dealt with and completed. You said that some NHS trusts have already indicated that the assimilation process will be halted while this is accomplished. How many are you talking about in Wales? Do you have specific evidence about specific trusts? I am very concerned about the evidence regarding the variability and the interpretation in benefits offices in relation to the lump-sum payments that some of the lower-paid staff receive. The Minister is clearly in a position to discuss the matter with the UK Government, but, once again, do you have specific evidence of those problems in local areas? Those of us who represent those areas would very much like to know when our benefits offices are not working according to UK Treasury guidance.

[103] In the Audit Committee, I gather that evidence was given that the financial shortfall in the total money available was, at least in part, due to a double calculation of some bank holidays. The Welsh Assembly Government, I gather, is in discussion with the UK Government to cover this. Are you aware of that issue, and are you therefore aware of what is happening in England, where the same double calculation must have taken place? So, it is a UK issue, and I am interested to know what is happening.

[104] On 'Agenda for Change' outside the NHS, you refer to 19 GP practices having introduced it. That is a drop in the ocean, of course. Are you aware of any efforts, specifically with regard to good practice in local health board areas, to encourage GPs to come on board with this? I have a real concern about school nurses. That, of course, could be tackled to a large extent by the LEAs, in many cases, as they are either employed by LHBs or LEAs, generally, unless they are in the independent sector. One assumes that the LHBs must be applying 'Agenda for Change' in terms of school nurses—tell me if I am wrong. However, in relation to local education authorities, they are much easier to work with, are they not? There are 22 of them, as opposed to thousands of independent GPs, and I wonder whether work is going on with them, because I am concerned about that.

[105] Finally, you mentioned the loss of nurse specialist posts; can you give us a ball-park figure of how many you think have been lost so far?

[106] **Ms Donnelly:** I will answer a few questions, and I will then ask members of the Royal College of Nursing panel to come in. First, with regard to 'Agenda for Change' outside the NHS, and the 19 general practitioners who are providing that, we have done quite a substantial amount of work with regard to lobbying, to ensure that general practitioners are aware of the need to implement 'Agenda for Change'. We have also set up, with the partnership forum working with the Welsh Assembly Government, a working task and finish group—I will ask Richard Jones to enhance the information that I have given in relation to that. Blaenau Gwent, for example, saw the first GP practice to award 'Agenda for Change' pay scales to nurses, simply because there was a problem with recruiting general practitioners there and nurse practitioners were necessary to deliver some of the services. So, the local health board directly employed nurses in Blaenau Gwent, and we used that as the precedent, as part of our negotiations. Richard, would you like to continue with that? I will then come back to the other questions.

[107] **Mr Jones:** I was involved in the task and finish group that was set up following the Royal College of Nursing's raising of this issue, and I am pleased that the Assembly Government took the issue on board. There are 504 GP practices across Wales, and we are working with LHB members and GPs, and with Ian Jones from the primary care directorate, to try to encourage GPs to implement 'Agenda for Change' for their staff. We have one GP practice in Cardiff, which is a single-handed GP practice, at which we are doing the pilot, and we also have a GP practice of five GPs in Swansea, which is taking 'Agenda for Change' fully on board. I go around talking to GPs when they have their LHB meetings, and one of the issues that they raise with me continuously is the fact that they would be more than willing to introduce 'Agenda for Change' for their staff, but that they believe that, under their GP contract, they do not have sufficient funding to pay their staff under 'Agenda for Change'. That, to me, is the biggest barrier to their introducing 'Agenda for Change'. I take this back to the partnership forum and I am told that it is there, but the GPs are telling me that that funding is not available. A solution to this would be for GP staff to be employed by local health boards.

[108] **Ms Donnelly:** That is GP nursing staff.

[109] **Mr Jones:** Yes, GP nursing staff.

[110] **Ms Donnelly:** With regard to the specific evidence requested on the slow progress in terms of the electronic staff record, we have, throughout Wales, a number of stewards who are located in all of the trusts, and I can identify that this is apparent within the three trusts in north Wales with regard to the electronic records, and it has become clear in my informal discussions with chief executives and nurse directors in the south Wales trusts that this is also an issue there. We cannot get to grips with the financial penalties that will be imposed if the electronic staff record is not implemented by 1 April. The difficulties that we are told are affecting the assimilation process—which is why we are so slow with regard to the assimilation, bearing in mind that we have matched about 97 per cent of jobs in Wales—are there because the human resource departments are working flat out to try to get the electronic staff record on board. That, coupled with the idea that every job in Wales and job family has to have a knowledge and skills framework portfolio, is a huge problem with regards to human resources in each of the trusts trying to work with an ever-extending workload.

[111] We are concerned that the people who are suffering the consequences of this are the nurses who are working. Our members are not receiving a sufficient amount of money in their pay packets because of the other problems that are being put to the human resource department. If we had people identified clearly within the NHS trusts who were solely linked to the assimilation of ‘Agenda for Change’ onto pay scales, the Royal College of Nursing would welcome it. We cannot realistically expect people to work on three or four different parts of implementing ‘Agenda for Change’ when they are all inextricably linked. The difficulty is that we are on a two-year-dated implementation date. We have gone past the two-year roll-out date and, if we are only at 50 per cent, we are really concerned that we are now going to be maybe three or four years down the line. So, in answer to your question, in terms of the three north Wales trusts, that is the evidence that we have had from our north-Wales office and the anecdotal evidence from informal conversations along the M4 corridor.

11.10 a.m.

[112] I will also take the question on school nurses. We raised this when we gave evidence last year to the Health and Social Services Committee, but the difficulty that we have in Wales in relation to school nurses is that there is a large number of school nurses that are employed directly by the local education authority. Unfortunately, in many of those areas, they are seen as a cinderella service and do not have access to the knowledge and skills framework or to the training and development that school nurses who are employed by local health boards have in terms of their funding. So, the difficulty that we have is that, in local education authority employment, again, it is a very piecemeal acceptance with regard to ‘Agenda for Change’, and the Royal College of Nursing advocated, last year, that we would like to see all school nurses come under the responsibility of the Minister for Health and Social Services with the follow-through of funding. I realise that that is within the domain of the Minister for Education, Lifelong Learning and Skills. Nevertheless, that is the problem that we are facing.

[113] There is an additional problem. We have also had changes in our regulatory framework with regard to the Nursing and Midwifery Council. Nearly two years ago, it brought in a third part of the register with annotations, which included, among others, health visitors, school nurses—all public health nurses. The problem is that it has annotated. It is a problem because we do not currently have sufficient training places in Wales for occupational health nurses. They are in the same position as school nurses, but school nurses, in particular, cannot access sufficient training to be able to assimilate onto that part of the register. A time frame will be imposed by the Nursing and Midwifery Council. It has not yet decided on that, but I had a letter from Kathy George, the head of regulations at the Nursing and Midwifery Council, which said that it potentially will be introduced this year, with a short timescale to allow sufficiently qualified nurses to assimilate. If they do not assimilate onto that part of the register, they will not be qualified to carry out their role.

[114] So, this is a huge issue, Jenny, in relation to school nurses, and we have recommended that all nurses come under the responsibility of the Minister for Health and Social Services via the local health boards. In that case, we would have the necessity to implement ‘Agenda for Change’, the knowledge and skills framework, and the training necessary to make sure that they are assimilated onto the third part of the register. If they are not, we will not have the number of school nurses that are currently employed and practising in Wales.

[115] With regard to the nurse specialists lost, I will respond first, and Richard might be able to come in with points that apply across the board. Certainly within Swansea NHS Trust, we have seen a large representation of nurses who are specialist nurse practitioners and specialist nurses who have contacted the Royal College of Nursing with regard to what they call a flattening down of their roles. We do not have a specialist nurse register in Wales, but we used to have one around eight years ago. However, the NMC currently does not register at that level, but we would be willing to come back to the Health and Social Services Committee on that. We could contact our members to ascertain the absolute numbers. We have been informed that this is happening in Swansea NHS Trust and Gwent Healthcare NHS Trust.

[116] Nevertheless, on visiting executive nurse directors, all executive nurse directors around the table were anxious about the fact that they will have to start looking at the specialist nurse practitioner grade, because it is costly. While some of that definitely needs to be done in relation to ‘Agenda for Change’, the reconfiguration and the knowledge and skills framework of the NHS, we realistically need to protect those specialist nurses that will be required to work in the community and use those skills. Unless we have some idea of what the workforce planning needs are in relation to implementing ‘Designed for Life’ in the community, we in the Royal College of Nursing fear that these specialist practitioners will be lost and that they will be subsumed, or that their jobs will be frozen, and that they will therefore be difficult to replace. We know that the bottom line of the nursing budget within each trust is being looked at in order to fund the deficits. I know that for a fact, and that applies to all the trusts.

[117] Lisa, could you pick up on the benefits and the specific evidence in relation to the short funding of our healthcare support workers and the relationship there?

[118] **Ms Turnbull:** This is a concern for us. We know that some guidance has been issued at a national level, but we are not clear on the interpretation of that guidance and whether everyone is aware of that situation. It would be problematic for low-paid workers to be suddenly, in effect, funding their own pay rise by removing the tax credits. Therefore, we are looking for some reassurance on that.

[119] **Ms Donnelly:** I will ask Gareth and Richard to succinctly deal with double calculation and some bank holidays.

[120] **Mr Jones:** On double calculations, I was not aware of that information. My concern is that, not at the last, but at the previous NHS partnership forum, we were given a reassurance that NHS finance directors were considering ‘Agenda for Change’ funding, and that we would be having a report back on that. My concern is that, as yet, we have not had that information. I do not know whether Gareth wants to say anything on that.

[121] **Mr Phillips:** No, not on the bank holiday issue.

[122] **Rhodri Glyn Thomas:** We have covered most of the area in response to Jenny’s questioning. I would now ask committee members to ask specific questions, so that we can bring everyone in. For those who want to raise issues other than issues relating to nurses and to the RCN, I am happy for them to do that. For example, if they want to raise other issues about ‘Agenda for Change’, they do not have to address all their comments to the RCN.

[123] **Jonathan Morgan:** On the funding issue relating to ‘Agenda for Change’, Tina, you said that other trusts were looking at staffing levels to cure the ‘Agenda for Change’ debt position. One option considered by Cardiff and Vale NHS Trust was to,

‘reduce the staffing establishment by an equivalent of 152 whole-time equivalent posts’.

[124] It is not clear whether that is nurses or other staff, whether clinical or non-clinical. What evidence do you have to suggest that the overall staffing number could be reduced among NHS trusts, in order to achieve a balanced budget position, particularly with regard to ‘Agenda for Change’? There is quite a gap, is there not, between what the Assembly Government has said on the one hand, and what the trusts have said on the other? It is a £25 million gap. It is not a small amount of money; we are talking about a significant difference in opinion between what is said in Cathays park and what is being said by NHS trusts. Do you have a view—and this may be rather cheeky—as to who is right?

[125] Before I move on from financing, may I ask what it is doing to staff morale? You are able to gauge the views of nurses throughout Wales, and this is being played out not just in the Assembly, but in the press. What is being done to the morale of staff who were given assurances about the implementation of ‘Agenda for Change’? Has there been any feedback on that, because I would imagine that some damage is being done?

[126] On recruitment and retention, you referred in your introductory remarks to the freeze on recruitment within NHS trusts. Could you outline which trusts have started to freeze recruitment, and how many posts have been frozen in recent months? I know that this is one of the options being considered by trusts, but I was given an assurance that this was not happening at present. You seem to have given a different response to the one that I had from the Assembly Government.

[127] On retention, one of the more draconian measures that has been considered—I know that, in certain cases, it has not been implemented, but it has certainly been considered—is compulsory redundancies. Are you aware of any NHS trusts, other than Cardiff and Vale NHS Trust—and I use that example simply because I have the documents in front of me—that have considered the possibility of compulsory redundancies in order to achieve a balanced budget, with part of that being the deficit situation relating to ‘Agenda for Change’?

[128] Finally, on the implementation of ‘Agenda for Change’, you have outlined the difference between the assimilation rates in Wales and England. What needs to be done to speed up the process of assimilation in Wales? What evidence is there of nurses losing out, compared with nurses in England, because of the differences in the assimilation rate?

11.20 a.m.

[129] Finally—and this is not specifically related to ‘Agenda for Change’, but it is something that would allow us, as an Assembly, to get to grips with many of these issues—are you concerned that we do not yet have an annual report from the chief nursing officer that can be debated in Plenary? This was a commitment given by the Government many months ago, but it has not yet been realised.

[130] **Ms Donnelly:** I will start with the question on the annual report from the CNO. The CNO has brought together all the professional organisations in Wales and has conducted two meetings to extrapolate from each of the professional organisations what we want to see in that report. I know that Nurse Executive Wales has been asked to contribute to that, and, potentially, the LHB nurse directors. I think that that is on track and should be ready to come to committee by July. There are some key issues in that report that the Royal College of Nursing will be pleased to see in relation to nursing in Wales.

[131] I will answer some of the other questions around the Royal College of Nursing. On the view as to who is right with regard to whether ‘Agenda for Change’ is fully funded—the NHS or the membership—we know from evidence given to us by the human resource directors that it is funded to 64 per cent. I think that the auditor general has identified a deficit of £25 million. I talk to members at senior nursing levels and those working in front-end services, and the difficulty is that when we look at a bank and agency budget within a trust, it realistically demonstrates the need for nursing skills. That is the true vacancy factor in relation to the delivery of care, because that is what is needed to deliver nursing skills. That is the budget. I recognise that between 15 per cent and 25 per cent of that is commission paid to agency staff. Nevertheless, NHS staff have been told that they cannot continue to employ agency nurses at the same rate, and they have to keep to a target of, I think, 2 per cent of the total nursing budget. However, I would have to have qualification on that from the director of NHS Wales.

[132] That means that those particular areas of trusts can no longer provide the services. I am acutely aware of hospital wards being closed, of nurses with long-term contracts being redeployed, and of some jobs being lost in some cases where nurses are coming up to retirement. In effect, that is to keep the bottom line of the nursing budget, but it is also done to try to identify some payback with regard to trust deficits. That is happening across all the trusts. I am particularly concerned about Bro Morgannwg, because the chief executive recently sent out a letter to staff, which came to the college through our trade union membership, which said that it needs to find £2 million and that some of that would come from what it hopes will be normal retirement. I have not heard of anywhere other than, potentially, Cardiff and the Vale talking about compulsory redundancies. However, to get back to our view, no, we do not believe that ‘Agenda for Change’ is fully funded. I have raised this question several times and I cannot get an answer with regard to a total package or the potential cost at the outset.

[133] I realise that there has been an increase in nursing numbers, but, unfortunately, you are asking me how it affects morale. It is having an immense effect on morale. At the Royal College of Nursing congress this year, I had the busiest time ever, as nurses from Wales were coming to talk to me to ask what was being done in Wales to ensure the safety of their jobs. It is not just about jobs being safe, but about the effect that it is having on patient care. The Royal College of Nursing undertakes an annual survey. We have 29,000 members, and nearly 8,000 members from Wales were included in that annual survey. The survey looks into the problem of the implementation of ‘Agenda for Change’, job losses, the effect on morale, and the effect of this on patient care and the fact that nurses regularly work for up to eight additional hours unpaid in the NHS in Wales because they cannot be paid fully. That is voluntary work, where nurses have to produce care for patients.

[134] If we look at how that affects morale, I wonder how many of us would volunteer to give a day’s work every week. I am not talking about a day per month, but a day per week—eight hours of voluntary services, whether it is in hand-over shifts or staying on to do a couple of hours to help someone out because they are engaged in patient care. It is the focus of patient care that is affecting morale; there are nurses going off feeling that they have not been able to contribute and close down holistically the patient care that they would want to give. That affects morale, and we are seeing it affect our young nursing population. We know that, certainly in Wales, between two and five years into the profession, young nurses are leaving it. That comes from our workforce survey data, which we could furnish the committee with if you needed to see it.

[135] The trust bottom-line figures in terms of the cost are where we are seeing the trusts trying to recoup some of the deficits. It will not be news to the committee that I have gone on record several times as requesting the Welsh Assembly Government to either write off those debts or enable staff to reconfigure services. We are seeing nurse directors having to reconfigure a service and, at the same time, come within a nursing budget that has been reduced in real terms. They have to fund bank and agency nursing and meet waiting-times targets at a time when funding is reduced. I recognise that there are deficits, but this is a huge part of the picture in terms of trying to recruit nurses to Wales and to keep them here.

[136] We are really concerned that we should not go down the same line that England is following. In congress this year, as I said, several nurses came to me and asked me what we were going to do about it. We hit the press with regard to Patricia Hewitt, and that was not staged anger from nurses; I emphasise that. We have nurses who feel similarly in Wales, and who have written in. We have seen an increase in our membership because of the way in which the RCN is lobbying, because they now think that we are doing something about it. I know that that is anecdotal, but, nevertheless, it gives you an idea of what morale is like in Wales.

[137] Having said that, we also have some of the highest achievers in Wales. There is potential for high achievers to get recognition and nursing awards, and, certainly, the Chief Nursing Officer funds special awards through the Florence Nightingale Foundation, which, again, Welsh nurses have achieved, and which have international recognition. It saddens the royal college to be in a position where we could have more of that if only the funding were there to meet the self-care deficits that patients have.

[138] With regard to the freezing of posts, we have been told through trade unions that posts are being frozen in the Conwy and Denbighshire NHS Trust and the North West Wales NHS Trust. Across the north Wales sector, in particular, nurses coming out of training in September are extremely unlikely to get posts. In fact, we have had approaches from the North West Wales NHS Trust to tell us that in advance. While we recognise that the Welsh Assembly Government funds student nurse training throughout Wales, we need some reassurances that student nurses coming out of training will get jobs—after all, it costs over £30,000 a year to train a nurse, and we are talking about a three-year course, so we are investing £100,000 in training nurses. We need to have that recognised in terms of giving them jobs at the end of it.

[139] In relation to the speed-up and assimilation, I will ask Richard or Gareth to take that up.

[140] **Mr Jones:** As far as assimilation is concerned, one of the biggest problems of all is the capacity of the pay departments. They are absolutely overwhelmed by the electronic staff record. That is one of the biggest problems of all. Unless you increase the staffing levels of skilled pay staff in order to undertake the assimilation, it will not take place for a long time. The pay unit is focusing on the electronic staff record because of the financial penalty that will be accrued by NHS employers in Wales.

[141] **Jonathan Morgan:** Tina, in response, you said that hospital wards were being closed. Are those hospital wards in acute hospitals or district general hospitals? Are we talking about permanent closures or not? I know that you made reference to it, and I was wondering whether there was any evidence that you could give us on that.

11.30 a.m.

[142] **Ms Donnelly:** Wards have been closed in hospitals in mid and west Wales. In relation to how those are presented to staff, it is to do with the reconfiguration of services. However, looking at the reconfiguration of services without the implementation of the mid and west Wales acute services review—and there was no nursing representation on that review—we do not know why those wards are closing. Certainly, we need to reconfigure services, but we also have to meet our targets on reducing expenditure and deficits.

[143] Carmarthenshire NHS Trust, in particular, has closed wards recently, some of which have only opened within the year as development areas. To me, that is about looking at delayed transfers of care and the transfer of patients back into the community. That particular trust was developing more of a ward environment to enable patients to be rehabilitated for discharge into the community, and that is still ongoing. There are still delayed transfers of care in Carmarthenshire, but those wards have now closed, and wards have also been amalgamated. We surmise from that that this cannot be due to reconfiguration, because we have not been involved. I do not know of any involvement of nurses in the reconfiguration that is out for consultation at the moment, that is, the document relating to the implementation of ‘Designed for Life’.

[144] Without an absolute plan it is difficult to determine whether or not hospital ward closures are indeed done in order to fall in line with the deficits. We recognise that there are deficits in Wales, but nevertheless we are calling for more time to pay those back to enable trusts to reconfigure their services to meet needs, and not just to do a quick fix. Closing a few wards to save money and meet the Assembly targets is not the right way to deal with patients and patient care. It is frustrating when nurses call you to say that their wards are closing and that they are being moved to another area, because the implication of that is that is those nurses have to be retrained. If you move from one area to another, it is not just about moving from a medical ward to a surgical ward, but different skill sets are needed to care for acute surgery patients. It happened in Swansea, where we had the closure of the cancer service and reconfiguration, with nurses being moved to other areas of the trust and told to go from palliative care to acute cancer care. A completely different set of skills is needed to care for somebody who is dying, and to give acute cancer therapy drugs.

[145] The idea is that you can move a specialist nurse practitioner back onto the ward when they are used to giving advice on moving patients back into the community, in the hope that you are going to cut your pay bill. Specialist nurse practitioners are in pay band 7, which commands about £24,000 to £28,000, but if you move those nurses back to ward level, and they need to be reconfigured and retrained, they no longer have the knowledge and skills framework to deliver that skill. Therefore, that is a demotion for those nurses, because they have to retrain. While they may be on a protected salary for two to three years, that does not necessarily mean that they will not have to work through the knowledge and skills framework again to get back onto ‘Agenda for Change’.

[146] I realise that that may be complicated, but, in essence, what I am saying is that if you have nurses moving from one speciality to another, there is a skills deficit. That skills deficit has to be clearly defined in terms of the knowledge and skills framework, there has to be funding to enable those nurses to be trained in that specific area, and then those nurses have to be given a mentorship opportunity. To equate it to a medical practitioner context, it would be like taking a consultant plastic surgeon and telling him to operate on an appendix. He might be able to do it, but his skills set would be such that the patient might suffer as a result. The Welsh Assembly Government and the National Assembly need to be made aware of this. I hope that that answers your question, Jonathan.

[147] **Jonathan Morgan:** Yes.

[148] **Rhodri Glyn Thomas:** The surgeon may well be able to do it, but I would not want him operating on me. [*Laughter.*]

[149] **Karen Sinclair:** Various people and other unions have raised with me a worry that, certainly in the north west of Wales, decisions on job matching are being phased to the finance. Do you also get that feeling? Obviously, that is totally contrary to what it is supposed to be about. However, there is a real fear around that and I just wondered whether you were picking up on the same feedback. I also have another question about a two-tier workforce within other areas.

[150] **Rhodri Glyn Thomas:** We will deal with that question first, and come back to the second question.

[151] **Ms Donnelly:** I will ask Gareth to comment on that, because he is our council member for Wales, and he is employed in north Wales.

[152] **Mr Phillips:** Anecdotal evidence from our members suggests that that is happening. The job-matching process was supposed to be objective and the results paid as the decision was made by the matching panel. We feel that that particular process has been undermined, and that the end results are being governed more by finance than the process of job matching.

[153] **Karen Sinclair:** Are you trying to move that from anecdotal evidence into something more solid?

[154] **Mr Phillips:** I would need to consult with colleagues a bit more about that to give you more quantitative evidence, but we are investigating it at a local level at the moment.

[155] **Rhodri Glyn Thomas:** If you get that quantitative evidence, a note to the committee would be useful and I will ensure that committee members receive that information.

[156] **Karen Sinclair:** I want to move on to cleaners' pay rates, because there is a real issue around what is, essentially, a two-tier workforce, certainly in some trusts. Work has been undertaken in respect of a protocol, which, I believe, has just been signed in England, that will commit employers to paying NHS rates of pay so that we do not have a two-tier workforce. What is happening about a similar protocol in Welsh NHS trusts?

[157] **Rhodri Glyn Thomas:** I do not know whether anyone is in a position to answer that.

[158] **Karen Sinclair:** I am quite satisfied just to put it on the record.

[159] **Rhodri Glyn Thomas:** Let us take a response from Ian, and if it needs further amplification we can have a note.

[160] **Mr Stead:** We announced to the partnership forum two meetings ago that we have agreed a similar arrangement in Wales, and funding has been given to those trusts affected.

[161] **Rhodri Glyn Thomas:** Karen, did you have anything else on that?

[162] **Karen Sinclair:** No, I am delighted with that answer.

[163] **David Lloyd:** I commend the presentation; a great many of the issues that I wanted to cover have already been covered. That is the very nature of things, but I am struck by the powerful evidence that we have heard this morning about 'Agenda for Change'. 'The Minister is here and will have heard'—that, I think, how the Presiding Officer puts it when we are in Plenary. However, I am sure that one issue would be not just his having heard this, but whether he would agree that these are issues that need to be tackled. At some point, it would be—

[164] **Rhodri Glyn Thomas:** Let me just stop you there, Dai. As I tried to explain at the start, this is a session for the RCN to offer evidence and for us to question the presenters. The Minister is present, and it is a matter for him if he chooses to respond, but he is not specifically required to do so.

[165] **David Lloyd:** I apologise. As you will recall, Chair, I am new to this committee so I am floundering in inexperience. Seeing as we have the Minister present, I thought that we might alight on an opportunity to ask him about this. However, I defer to your greater experience in these matters. I would like just to tidy up one or two issues. We have received evidence about difficulties with 'Agenda for Change' from other professions such as pharmacists, but particularly within the nursing sphere and from health visitors. Can we give health visitors a floor in terms of the evidence for the Minister? To amplify the part in your evidence about clinical nurse educators and the particular difficulties that they face vis-à-vis 'Agenda for Change' and being left behind, as it were, we cannot do without clinical nurse educators, although they are not often mentioned.

[166] As regards the very detailed part of your paper that talks about the assimilation process, the knowledge and skills framework and the different percentages with regard to what has been completed in England and in Wales, Jonathan asked what could helpfully be done, specifically from the RCN's point of view, to speed up the assimilation process and the knowledge and skills framework. As regards the assimilation, is it just a matter of the electronic payroll being sorted out or could other things be done to speed up the assimilation process?

11.40 a.m.

[167] Basically, the other point is about the huge challenge that is ‘Designed for Life’. I know that the Royal College of Nursing has been heavily in favour; 88 per cent voted for ‘Agenda for Change’ years ago in terms of the whole framework for moving on, and you are obviously also in favour of ‘Designed for Life’, but there are huge and significant challenges in what is envisaged by ‘Designed for Life’ in the sphere of more community services. Would you care to expand on those challenges and how they apply to this ‘Agenda for Change’ situation?

[168] **Ms Donnelly:** I will ask Richard to talk about nurse educators. Gareth, are you prepared to talk about health visitors and the assimilation into ‘Agenda for Change’? I will pick up anything from those two issues and the question about the challenges of ‘Designed for Life’ later.

[169] **Mr Jones:** As far as nurse educators are concerned, you have to first look at the background of where these nurse lecturers come from. They must have a significant amount of experience as registered nurses, working in clinical environments, before they work in the HE sector. They work as lecturers, senior lecturers and principal lecturers, and they must have a good academic background as well as the skills to teach nursing care.

[170] The difference between nurse lecturers in the higher education sector and other lecturers in other disciplines, is that they must have the skills to actually teach the practical skills to nursing students. So, they have a clinical component to their role. Therefore, they are recruited from the health service, be it in the independent sector or, predominantly, from the NHS. When you look at salaries in the HE sector, a senior lecturer at the top of the grade, compared with a nurse consultant on ‘Agenda for Change’—which is a comparable grade—there is a £6,000-a-year significant difference in the salary that people with that skills set would earn if they worked in the national health service.

[171] Within the job evaluation framework in HE, there is no weighting accredited to clinical expertise, and we would like that to be included in the job evaluation, particularly for nurse lecturers. Some credence should be given to their expertise in clinical care. A big problem is that, in the next six years, 50 per cent of nurse lecturers in Wales are due to retire. We must encourage people to work in higher education. If they do not have the pay and the terms and conditions to encourage them to work in higher education, we will not be able to train and educate our nurses of the future.

[172] **Mr Phillips:** I suspect that the situation with health visitors arose because of the poor national profile to which the majority of health visitors were matched. In Wales, our health visitors need to undertake post-registration degree-level education, and their training, with experience and so on, would amount to about six years’ worth of training, and they would come out, currently, on a band 6, between £20,000 and £28,000, which, for six years as a student, does not seem a lot. Given that we think that the national profile had a poor reflection of the job weighting required and the responsibilities of the job, we have submitted extensive reviews, on behalf of our health-visitor members, for a review of that particular banding. We are hoping that that review will identify the shortcomings in the national profile and give them the much more appropriate banding of, I would imagine, a band 7.

[173] **Ms Donnelly:** Richard, can you respond to Dai’s question on speeding up the assimilation process? I will then come back, if I may, on the challenges of ‘Designed for Life’.

[174] **Mr Jones:** I mentioned increasing the number of staff in the pay unit. In addition, one of the things that we are currently seeing, because of the electronic staff records, is that staff are being moved out of ‘Agenda for Change’ to work on the electronic staff records. We need ‘Agenda for Change’ to be a priority and for NHS employees in Wales to work full time on its assimilation. Lots of trade union members have to fulfil their role as clinical nurses as well as helping with assimilation, so we need more focus on the assimilation process and for it to be a priority.

[175] **Ms Donnelly:** Thank you. With regard to the challenges in ‘Designed for Life’, I do not know where to start, really, because it is enormous in relation to, potentially, nursing patients in their own home. I talk about nursing patients because we recognise that there is evidence—and we could provide the committee with evidence ad infinitum on this—that patients who are looked after by registered nurses do very well, in terms of morbidity and mortality, as opposed to those who do not have a registered nurse or registered care practitioner.

[176] With regard to the challenges for ‘Designed for Life’, ‘Agenda for Change’ was set up to meet the challenges of the reconfiguration of the workforce across the UK in terms of different ways of working. The Royal College of Nursing and its members have embraced much of that in terms of taking on new roles, often doing some of the work that our medical colleagues have needed to share out because of the patient experience. Nevertheless, in Wales, we have—and in ‘Agenda for Change’ there is a pay formula between bands 1 and 9—very few at level 4, which is the assistant practitioner grade, which is, in essence, support to nurses or to any other healthcare practitioner who is on the register. The difficulty that we see with regards to the challenges in ‘Designed for Life’ is that—and I touched on this earlier—if you are going to move patients into the community, you will be moving them into a community that does not have the infrastructure that you have within the acute care sector. With that goes the medical support and all the support of the allied health professional groups and nursing. They prescribe care but they also monitor and supervise care, part of which is in relation to the accountability that they have to the regulatory body. In Wales, all our registered practitioners prescribe care but, importantly, they also take the accountability for anybody below band 5 of ‘Agenda for Change’. So, that means an unregulated healthcare provider.

[177] We participated—I think that it was three years ago now—in a consultation on the regulation of healthcare support workers, on which the Department of Health had the lead; I understand that the Chief Nursing Officer for Scotland, who is also the interim director of human resources, is currently piloting some of the healthcare practitioners with regard to healthcare support workers of level 4 and below. Is the committee with me at this point? I see that it is. We in Wales have concerns that that is being piloted in Scotland. The consultation was for England and Wales and we would like to see some consultation around how we might look at the regulation of some of our members at healthcare-support-worker level and, particularly, at the assistant practitioner grade. In the knowledge and skills framework on ‘Agenda for Change’, that grade is about responsibility and accountability for prescribed levels of care. We are going to be moving these patients into the community and we are potentially going to have an increase in level-4 band practitioners, who are currently unregulated. We are not going to need fewer nurses to supervise their care; we are going to need more, because they are in an isolated, community setting. They will not have the infrastructure, unless they have the regulation that follows through with that. With that, I would be expected to be looking at the knowledge and skills framework in terms of standards and the commissioning of education from the reorganisation and reconfiguration of health services throughout Wales. We have a difficulty with that in the college. We have healthcare support workers within our membership, but what does ‘assistant practitioner’ mean?

11.50 a.m.

[178] Until we have some job profiles of what is going to be accepted as the provision of care within the community—and I recognise that the three documents with regard to the regions are out for consultation at present—I have a real concern about the lack of nursing involvement in facing up to some of those challenges, specifically in mid and west Wales. I have raised this before. I have raised in all possible circles getting nurses around the table at the conception of some of these ideas in order to discuss the infrastructure, but it did not happen in mid and west Wales. Unfortunately, at the launch of that, I was sitting in the audience listening and thinking, ‘All of these challenges are for nursing and there is not a nurse around the table on that group’. The concern that I have is how then we can hope to meet those challenges and identify the issues within mid and west Wales. Certainly, that is not the case in the north Wales region or in south-east Wales. There has been nursing involvement there. Yet is the nursing staff who will be responsible for the supervision of care in the community provision.

[179] I have concerns about the unified assessment process and, potentially, the electronic patient record. We have done some work with the NHS Confederation and the British Medical Association, and we are all of the same mind: we are talking about clinical leadership within Wales and the clinical leadership necessitating patient care in the community. Those clinical leaders are people who hold a professional regulatory accredited qualification in order to protect the public, and that is of immense importance to us. It is important for us in the Royal College of Nursing, not least because of the patients that we are caring for, but also because we are having to protect nurses if they run into difficulty in providing care over a large surface area in terms of some of the areas in Wales.

[180] In many isolated areas the challenges are immense. I have huge concerns with regard to where we are in terms of determining what healthcare education needs will look like, how that fits in with the knowledge and skills framework and how we fit into the regulatory mechanism—if we regulate. It is still in abeyance, so we do not know. I am just talking about NVQ level 4, of which we do not have many in Wales. We have a substantial number—26,000 to 27,000, I think—of healthcare support workers, in Wales, across the board, many of whom are at the lower pay band scales of the 'Agenda for Change' and who need to be assimilated onto that knowledge and skills framework to enable them to progress up the career pathway. The Royal College of Nursing is eager to be involved in perhaps looking at accrediting study centres so that we can have on-the-job training so that healthcare support workers can be trained alongside nurses in order to prepare for the move of patients into the community.

[181] I do not know whether or not that answers your question, Dai.

[182] **Rhodri Glyn Thomas:** It will have to answer Dai's question because we are slightly over-running on time. [*Laughter.*]

[183] **Ms Donnelly:** You can see that I am passionate about it.

[184] **Rhodri Glyn Thomas:** In fairness, I know that Karen wants to come back on one specific issue. I want to do that. This is a huge issue, on which we could go on for a long time, but I think that you have covered the main points, Tina.

[185] **Karen Sinclair:** Hopefully, you will be able to give me a brief answer. What work have you done, and what consistency of job matching is there across health trusts, particularly for healthcare assistants?

[186] **Ms Donnelly:** There is consistency checking.

[187] **Mr Phillips:** At present, consistency is provided by the equality group and the computer-aided job evaluation scheme. Results are coming out from the consistency checking at present, and I hope to consult with my colleagues on the result of that. We were discussing it this morning, and the up-to-date situation with regard to that.

[188] **Rhodri Glyn Thomas:** Thank you very much. It has been a very informative session. It is important that we do take opportunities to raise issues that are of current interest and concern. I am flexible in that matter. I would encourage committee members, if they have issues that they feel need to be aired in the committee to raise them: if I can, in any way, find a way to include those on the agenda, I am happy to do so.

[189] I thank the Royal College of Nursing for its evidence. It is recorded and noted, and I am sure that we will come back to you on a lot of those issues in further sessions of the committee.

[190] On the chief nursing officer issue, which Jonathan raised, we have had the commitment. It will be coming to the committee in July. My understanding is that the annual statement of the chief nursing officer is just that—an annual statement. Although the committee set-up will be different after 2007, we would expect that statement to be made, in one way or another, to Plenary and, hopefully, to a committee, after 2007.

11.54 a.m.

Mesur Comisiynydd Pobl Hyn (Cymru)
The Commissioner for Older People (Wales) Bill

[191] **Rhodri Glyn Thomas:** Fe gofiwch ein bod wedi trafod y mater hwn y llynedd, ar 25 Mai, ond ers hynny mae'r Mesur wedi bod drwy Dy'r Arglwyddi, ac yn ôl i Dy'r Cyffredin ar gyfer craffu. Mae gennych bapur oddi wrth wasanaeth ymchwil yr Aelodau, sy'n nodi'r newidiadau a'r gwelliannau i'r Mesur ers hynny. Dyna yw maes y drafodaeth hon.

Rhodri Glyn Thomas: You will recall that we discussed this issue last year, on 25 May, but the Bill has since been through the House of Lords, and back to the House of Commons for scrutiny. You have a paper from the Members' research service, which notes the changes and amendments to the Bill since then. That is our focus this morning.

[192] Deallaf mai'r Dirprwy Weinidog sy'n arwain ar y mater hwn, oherwydd ei gyfrifoldeb am bobl hyn yn y gymdeithas. A oes gennych sylwadau i'w gwneud fel cyflwyniad, John?

I understand that the Deputy Minister is leading on this issue, because of his responsibility for older people in our communities. Do you have any introductory comments, John?

[193] **John Griffiths:** We are pleased with the timely progress that we have been able to make. We got the Bill before the Houses of Parliament, and into the House of Lords, before we expected, in many ways, which was good. It has since had a constructive time in the House of Lords, where we have seen the clarification and strengthening of the Bill. Some 54 Government amendments have achieved that, and it currently awaits Second Reading in the House of Commons. We hope that there will be a date for that Second Reading fairly quickly. Therefore, there has been satisfactory progress to date. If we can follow that through in the House of Commons stages, we will be pleased.

[194] **Jonathan Morgan:** I have a few comments and questions on some of the amendments that have been approved in the House of Lords. I welcome the fact that clause 11 was amended to ensure that, where a person fails to comply with a request for information, it will be covered by the obstruction and contempt provision, which is usually found in other situations. I am delighted with that, because it is right that—please excuse the pun—the commissioner for older people should have some teeth. That is necessary. If someone is going to be effective in the role of sticking up for older people in the way that you envisage, then having that, in order to demand that information is made available, is important, and I am pleased that it will be in statute.

[195] On clause 9, on research and educational activities, you say that the new clause will allow the commissioner to commission or provide assistance for research. That is an important function, and could be crucial in terms of the way in which the commissioner can gather information and commission further research into particular fields of concern. Commissioning research can be expensive, and it is not a question of statute, but perhaps of resourcing, as to whether the Government will accept that there is a potential resource implication to that. I would like an assurance that, if the commissioner for older people wishes to commission a piece of research that would assist his or her discharge of functions, resources will be available for the commissioner to undertake that function.

[196] I was particularly keen on two aspects. The first relates to clause 16, and the second relates to clause 17. On clause 16, on working jointly with the Public Services Ombudsman for Wales, in terms of joint working, at present, any report that is produced by the Public Services Ombudsman for Wales goes to the First Minister. What do you envisage happening to a report that is done jointly by the public services ombudsman and the commissioner for older people? Will that also go to the First Minister, or will it go to someone else? I am aware of a particular route that is pursued at present by the public services ombudsman, but how does that fit into a joint-working arrangement with the commissioner for older people?

[197] I welcome clause 17 on the collaborative working arrangement between the commissioner and the Public Services Ombudsman for Wales. Many of the older people that I have dealt with in my seven years as an Assembly Member, who have had to make use of the public services ombudsmen—particularly the health service ombudsman—have expressed concerns about how enquiries are dealt with, how investigations are conducted, and the fact that there is no mechanism beyond the ombudsman's report. Therefore, I am pleased that there will be that sort of collaboration, because, something needs to be done to improve the view that many older people have of those in authority who conduct this sort of investigation, and perhaps that collaborative working could be one way of assuring people that their best interests are at the heart of what the commissioner will do.

[198] I have a final question, which relates to the complaints procedure in respect of the commissioner. I welcome the fact that there will be an opportunity for older people to pursue a particular complaint if they feel that their particular issue has not been investigated properly or that they have not had proper justice. However, can the Government investigate whether this could be extended to the public service ombudsman? The ombudsman is the final court of appeal; there is nowhere to go beyond that apart from undertaking a judicial review. If we are going to have a form of complaints procedure built in for the commissioner for older people, could that not be extended to, for example, the health service ombudsman, who is the final court of appeal when someone makes a complaint about the health service? I am not quite sure who would be responsible for analysing that, but that might be another avenue for some reform in the future.

[199] **John Griffiths:** I welcome those comments, and one thing that has been impressive throughout this process of taking forward the legislation for a commissioner for older people in Wales has been the level of cross-party support. That was certainly apparent in the House of Lords, and it has also been a feature of the Assembly's deliberations and this committee's discussions. I welcome the constructive nature of Jonathan's remarks and questions. It is true that this requirement for strengthening the commissioner's ability to require information will mean that the commissioner is able to play a stronger role for older people in Wales than would otherwise be the case. That is also the case with regard to the research and educational activities.

[200] There are resource implications. The budget will be negotiated along the lines of the children's commissioner's budget as this goes forward, and the initial allocation will be similar to the children's commissioner's budget. If, at any time, the commissioner for older people thinks that the resources are inadequate, then there is a process to allow for those concerns to be addressed. There can never be any blank cheques, as I am sure we are all aware. So, the usual process will be followed.

[201] The amendments on collaboration and joint working are important, and that was reflected in the committee's previous discussions on the Bill. Many people made the point that unnecessary duplication should be avoided and that there should be collaboration and joint working. Thankfully, that element has been strengthened and clarified through the amendments that have come forward in the House of Lords. That is something that we would all welcome.

[202] I will ask officials to answer the question on whether a joint report would go to the First Minister. If they are unable to answer that question, I am sure that we can write to Jonathan with that information.

[203] **Ms Lockwood:** It would be a matter for regulations to specify, but the Assembly Government helped to provide a statement of policy intention in the House of Lords, which indicated who was likely to be included in regulations as the people who would receive copies. In paragraph 45 of that, the First Minister is listed, as are the libraries of the Assembly and the Houses of Parliament and those involved in the investigations.

[204] **John Griffiths:** Your comment on the possibility of extending the complaints procedure to the public services ombudsman was interesting, Jonathan. As this model develops, we may see implications for other similar bodies in Wales. However, it is all speculation at the moment.

[205] **Jenny Randerson:** I have two questions. One is a general question about the remit of the commissioner, and the possible duplication between the role of the commissioner and the new commission for equality and human rights. On the surface, this appears to be running counter to the general thrust of Government policy, which is that you roll it all together and create a one-stop shop. I know that the Government is talking about a single equality Act as well, although that will obviously be further down the road; I wish it were not, but it will be. So, the point is that legislation will be coming in in October or November, I think, in which there will be obligations against age discrimination. That is quite narrow legislation, but it means that there will be some overlap, will there not, between the role of the commissioner for older people and the commission for equality and human rights? I am interested in how they would work together or how they would agree to divide up the work that is to be done, so that there is no duplication, and, also, importantly, so that the people who might wish to use these services would know which one to go to, or are signposted to the right place.

[206] The second, specific, point is that Clause 13 explicitly provides that the commissioner or an authorised person can,

‘interview the older person in private, if the older person consents’.

[207] There has been an amendment that enables them to be interviewed,

‘in the presence of another person, if that is what the older person wished’.

[208] I have come across this issue in relation to interviews with older people living in residential accommodation, in nursing homes and so on, and people coming in from housing associations to interview those residents to see whether they are happy with the way in which the place is run. A lot of older people, the older and frailer they become, feel unable to say ‘no’, and feel as if the people running their home are in some position of control over them. They also feel frightened of them. We are talking about people who could well be complaining about abuse in care homes in this kind of situation, are we not? I am deeply concerned that the amendment needs strong guidance and real safeguards in terms of action in practice, to ensure that there is a presumption that people will be interviewed in private, and that they will only be interviewed in the presence of someone else if there is a strong indication that they should be—it could be a clinical need or something. I am worried that, in practice, that amendment now means that there will be an assumption that someone else will be there. However, older people, when their complaint has been lodged, need an assumption that they will have privacy in order to make a statement.

[209] **John Griffiths:** It will be important to ensure that the new commission for equality and human rights works effectively with the commissioner, and vice versa. I am sure that, in due course, the Assembly will consider regulations to add the CEHR to the legislation in the same way that the Public Services Ombudsman for Wales will have collaborative and joint working with the commissioner for older people. I am sure that it would be an obvious thing to do to bring the CEHR and the commissioner for Wales into that collaborative and joint working.

[210] It is true, as you said, Jenny, that the legislation that is coming in in October on age discrimination and age equality will be limited, largely to employment and employment-related training, so that shows that it will be limited in terms of impinging on the duties and the functions of the commissioner for older people in Wales. There will still be a strong need for a commissioner for older people in Wales in that regard. The age limit will be 60-plus, and a lot of the people with employment and employment-related training issues will be in the 50-60 age group, which, at one stage, was considered to be included, but will now not be.

12.10 p.m.

[211] In terms of dividing up responsibilities, we would be looking at a memorandum of understanding between the commissioner for older people, the new body and the commissioner in Wales to divide up those responsibilities, as you suggest. That is an accepted and effective way of dealing with those matters. Signposting is included in all of that, Jenny, and there are requirements for the older people's commissioner to let the public services ombudsman know if he or she is dealing with a case that is also within the jurisdiction of the other. That works both ways. I would envisage that that would apply to the new commission for equality and human rights and the commissioner in Wales. All of that should adequately cater for the issues that you rightly mention.

[212] On clause 13 and the right of an older person to have another person present at an interview if they so wish, this was added as an amendment to deal with the concerns that you raised. I take your point that it needs to be strengthened further, and the commissioner can issue guidance on this, as you mentioned, Jenny, if the commissioner thinks that there are problems with the way it operates, having had some experience of it. The commissioner is also able to review arrangements for advocacy, whistleblowing, complaints and dealing with dignity issues. That is something else that was added and something that comes to me a lot as the Minister with responsibility for older people in Wales. There are many dignity issues involved in all of this, so I am glad that it was added, because it is very important. However, in reviewing those arrangements and making reports and recommendations, the commissioner will be able to deal with these issues, and advocacy is very important in terms of the support that you mentioned that older people may well need.

[213] **David Lloyd:** I may have mentioned earlier that I am new to this committee, and the points that I wanted to bring up have already been covered. I want to have some clarity in my mind about the situation when we have a commissioner in place. He or she could be confronted by someone who has an issue about a non-devolved matter. There was no requirement on the UK Government to pay any heed or attention to what the commissioner might say about it. Has that situation changed with the passage of the legislation in other places?

[214] **John Griffiths:** The commissioner will be able to make representations to the UK Government on any matters affecting the interests of older people in Wales. The Wales Office has made it clear that it would envisage the same type of arrangements that apply to the children's commissioner. Therefore, if the older people's commissioner wanted to meet any of the Wales Office Ministers to discuss a particular matter, that meeting would be facilitated and representations would be made to the relevant and appropriate UK Government Minister. There has been an exchange of letters between us and the Wales Office to clarify and formalise this arrangement to some extent. However, it is true to say, Dai, that the UK Government has been very clear that it does not see this legislation changing the devolved settlement, and it cannot do so. So, where the UK Government is the responsible government on any particular issue, the issues of accountability rest with UK Ministers, but subject to the process that I described.

[215] **Karen Sinclair:** I want to go back to Jenny's point on clause 13 because it could have implications, especially if people are in care establishments and there is a conflict of interest between the role of the carer as a carer and the role of the carer as a businessperson. I worry that if the presumption that the person could have someone else present only if that person so wished was abused prior to any sort of interview, it could significantly stymie the work of the commissioner and totally undermine his or her role. I listened carefully to Jenny, and I think that she is absolutely right. Her use of the phrase, 'deeply concerned', is legitimate, and that is about the right level of concern, because there could be situations, even if there were care staff who were feeling intimidated and who were not into whistleblowing; they could be in that difficult position as well.

[216] **John Griffiths:** I entirely accept all of that, Chair. As I said earlier to Jenny, it is for the commissioner and the older person to deal with these matters, and the commissioner would have to consider all this in his or her general functions. Various avenues are open to the commissioner in terms of reports, recommendations and guidance to deal with this. In the light of experience, I am sure that that will take place; they are very real issues and I am sure that we will all take a close interest in them once the commissioner is in being and is operating.

[217] **Rhodri Glyn Thomas:** Diolch. Yr ydym wedi edrych ar y newidiadau a'r gwelliannau. Fe fydd y broses honno'n barhau.

Rhodri Glyn Thomas: Thank you. We have looked at the changes and the amendments. This process will continue.

[218] Mae gennym bapurau i'w nodi. Cyfeiriaf eich sylw at bapur 5, sy'n ymdrin â'r newidiadau i gyllidebau 2006-07. Mae Steve Elliot o'r is-adran gyllid yn yr adran iechyd, rhag ofn bod gennych gwestiynau.

We have papers to note. I draw your attention to paper 5, which is on the changes to the 2006-07 budgets. We have with us Steve Elliot from the finance division within the health department in case you have any questions.

[219] **Brian Gibbons:** Chair—

Brian Gibbons: Gadeirydd—

[220] **Rhodri Glyn Thomas:** Weinidog, a oes gennych gwestiwn ar y newidiadau? [*Chwerthin*.]

Rhodri Glyn Thomas: Minister, do you have a question about the changes? [*Laughter*.]

[221] **Brian Gibbons:** No, it is a question about process. Is it not the case with such papers that we are given some notice, so that we can have the necessary officials here?

[222] **Rhodri Glyn Thomas:** Yes, because I anticipated that there may be questions, and therefore we needed him.

[223] **Brian Gibbons:** Obviously, Steve will be able to answer questions in this context, but there are many papers to note and, because we have not had prior notice, not all the relevant officials will be here to respond, in the case that I cannot pick up points. I seek your clarification that if people are to raise points, the due process is that we are informed that points are to be raised.

[224] **Rhodri Glyn Thomas:** It is a little difficult, because we were informed about the changes to the budgets in the last few days, and the paper is there because it is of current interest. However, I take your point: if we have prior notice, we would inform you of specific questions. I understand that, especially with finances, you sometimes need a detailed answer.

[225] **Brian Gibbons:** Would the expectation be that there would be prior notice?

[226] **Rhodri Glyn Thomas:** Yes, that would be the expectation, as long as the timescale allows it.

[227] **Jonathan Morgan:** May I suggest that this be included on the agenda next time?

[228] **Rhodri Glyn Thomas:** I am happy to do that. If people have specific questions, please give them to the clerk, and we will make sure that the Minister and officials are informed.

[229] Dyna ddiwedd y cyfarfod. Diolch yn fawr ichi.

That brings the meeting to a close. Thank you.

Daeth y cyfarfod i ben am 12.19 p.m.
The meeting ended at 12.19 p.m.