Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

The National Assembly for Wales
The Health and Social Services Committee

Dydd Mercher, 5 Gorffennaf 2006
Wednesday, 5 July 2006

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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), Lorraine Barrett, Brian Gibbons (y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol), John Griffiths, Helen Mary Jones, Jonathan Morgan, Lynne Neagle.

Swyddogion yn bresennol: Ann Lloyd, Pennaeth, Adran Iechyd a Gofal Cymdeithasol; Dr Tony Jewell, Prif Swyddog Meddygol; Mike Shanahan, Cyfarwyddwr, Y Gyfarwyddiaeth Polisi Pobl Hŷn a Gofal Hirdymor; Richard Tebboth, Arolygiaeth Gwasanaethau Cymdeithasol Cymru.

Eraill yn bresennol: Dr Malcolm Adams, Cyfarwyddwr, Canolfan Ganser Felindre; Sian Evans, Prif Fferyllydd, Canolfan Ganser Felindre; Anne Mills, y Coleg Nyrsio Brenhinol, Pennaeth Nyrsio a Therapi, Canolfan Ganser Felindre; Dr Andrew Fowell, Meddyg Ymgynghorol mewn Meddygaeth Liniarol, Ysbyty Gwynedd; Maureen Noonan, Cymdeithas a Choleg y Radiograffyddion.

Gwasanaeth Pwyllgor: Jane Westlake, Clerc; Sara Mansour, Dirprwy Glerc.

Assembly Members in attendance: Rhodri Glyn Thomas (Chair), Lorraine Barrett, Brian Gibbons (the Minister for Health and Social Services), John Griffiths, Helen Mary Jones, Jonathan Morgan, Lynne Neagle.

Officials in attendance: Ann Lloyd, Head, Health and Social Care Department; Dr Tony Jewell, Chief Medical Officer; Mike Shanahan, Director, Older People and Long Term Care Policy Directorate; Richard Tebboth, Social Services Inspectorate for Wales.

Others in attendance: Dr Malcolm Adams, Director, Velindre Cancer Centre; Sian Evans, Chief Pharmacist, Velindre Cancer Centre; Anne Mills, the Royal College of Nursing, Head of Nursing and Therapies, Velindre Cancer Centre; Dr Andrew Fowell, Consultant in Palliative Medicine, Ysbyty Gwynedd; Maureen Noonan, Society and College of Radiographers.

Committee Service: Jane Westlake, Clerk; Sara Mansour, Deputy Clerk.

Dechreuodd y cyfarfod am 9.31 a.m.
The meeting began at 9.31 a.m.

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

[1] **Rhodri Glyn Thomas:** Bore da a chroeso i bawb i'r cyfarfod, sy'n cael ei gynnal yn y Siambr y bore yma oherwydd trafferthion technegol yn yr ystafell bwyllgora.

Rhodri Glyn Thomas: Good morning and welcome to you all to the meeting, which is being held in the Chamber today owing to technical difficulties in one of the committee rooms.

[2] Os byddwch yn cyfrannu, gwnewch yn siŵr fod y golau coch wedi ymddangos ar y meicroffon. Nid oes angen ichi gyffwrdd ag unrhyw beth; arhoswch nes bod y golau coch yn ymddangos er mwyn sicrhau nad oes geiriau'n cael eu colli ar ddechrau eich cyfraniad. Gwnaf gais hefyd ichi beidio â defnyddio'r cyfrifiaduron sydd o'ch blaenau,

If you wish to make a contribution, please ensure that the red light has appeared on your microphone. You do not need to touch anything; please wait until the red light appears so that the first words of your contributions are not lost. I also ask you not to use the computers because it would create problems if you logged on.

oherwydd byddai'n creu problemau pe baech yn logio ymlaen.

[3] Mae offer cyfieithu ar gael, sydd hefyd yn cynyddu'r sain os bydd pobl yn cael trafferth clywed yr hyn sy'n cael ei ddweud.

Translation equipment is available, which can also be used for amplification if you have difficulty in hearing the proceedings.

[4] Yr ydym wedi derbyn ymddiheuriad gan Lynne Neagle a fydd ychydig yn hwyr. Mae Lorraine Barrett yn dirprwyo ar ran Karen Sinclair.

We have received apologies from Lynne Neagle who will be slightly late. Lorraine Barrett is substituting on behalf of Karen Sinclair.

[5] Os nad oes unrhyw ddatganiadau o fuddiant, awn ymlaen at adroddiad y Gweinidog.

If there are no declarations of interest, we will move on to the Minister's report.

9.32 a.m.

Adroddiad y Gweinidog
Minister's Report

[6] **Rhodri Glyn Thomas:** Edrychwn ar eitemau 1 i 4 yn gyntaf.

Rhodri Glyn Thomas: We will look at items 1 to 4 first.

[7] **The Minister for Health and Social Services (Brian Gibbons):** Chair, someone has asked me to say a few words on 'Agenda for Change' as an additional item. I do not know whether you want me to do that.

[8] **Rhodri Glyn Thomas:** Cymerwn hynny yn gyntaf felly, Weinidog.

Rhodri Glyn Thomas: We will take that first then, Minister.

[9] **Brian Gibbons:** This was basically about trying to get an update on where we are with 'Agenda for Change'. Towards the end of June, 91 per cent of staff in the NHS in Wales had been matched under 'Agenda for Change'; 67 per cent had been consistency-checked and had been passed to the payroll; and 47 per cent were in receipt of 'Agenda for Change' pay. It is anticipated that the full transition to 'Agenda for Change' will approach completion towards the end of the year. We will be aware that this year's allocation to the NHS for 'Agenda for Change' has been £57.7 million, which varies from £12.5 million for the ambulance service—in other words, 22 per cent of the total allocation this year goes to the ambulance service—down to smaller amounts in places such as Ceredigion, Carmarthenshire and the Vale. In terms of organisations that have moved towards receipt of pay, the number of staff varies from a high number in organisations such as Ceredigion NHS Trust, where receipts have been paid for over 90 per cent of staff, to lower numbers in organisations such as Velindre NHS Trust and the Wales Ambulance Service NHS Trust, which are at around 20 per cent.

[10] **Jonathan Morgan:** I will just raise two particular questions in relation to what the Minister has just said. First, there are financial discrepancies between what NHS trusts are saying that they need and what the Assembly Government has allocated. What meetings have been taking place in the past two months and what meetings are planned to try to reach some level of understanding or agreement between what the Assembly Government has been willing to offer and what the trusts are saying that they need to implement this?

[11] Secondly, what process of assessment has been undertaken, because, clearly, the

Government will say that it believes that it will cost x million to implement 'Agenda for Change', but the NHS trusts have a different view on this? What is the process that will enable trusts to realise the potential of 'Agenda for Change' without incurring a significant financial hardship?

[12] **Rhodri Glyn Thomas:** A oes unrhyw gwestiynau neu sylwadau eraill ar 'Agenda ar gyfer Newid'? Gwelaf nad oes.

Rhodri Glyn Thomas: Are there any other questions or comments on 'Agenda for Change'? I see that there are not.

[13] **Brian Gibbons:** We are in fairly regular contact with the trusts, mainly through the regional office, but even, on occasion, on a bilateral basis with the centre here, on a wide range of issues in relation to their financial status. That would cover things such as local delivery plans, how they are getting on with 'Agenda for Change', how they are generally managing their deficits, and discussions on their strategic change and efficiency plans and service and financial frameworks in terms of delivering targets. Very often, a whole bag of issues are being raised on an ongoing basis in terms of trying to maintain the financial balance of trusts.

[14] It is possible to speculate, but with less than 50 per cent of the organisations fully paying out on their staff, it is still too early to indicate. As I pointed out, the ambulance service has only moved approximately one fifth of its staff over to payment as we speak, and the fact that it is taking up something in the order of 20 per cent of the allocation indicates some of the uncertainties that are in the system. However, I do not think that anyone would argue that this system is not under financial pressure, and, almost certainly, there will need to be further discussions at some stage. Giving our estimate of the gap at this stage would not be the best way to proceed, because it is almost tempting people to bid up or bid down to whatever they think our estimate is. We want to see rigour in this procedure, and we want to see that everyone gets fair play and value for the work that we are doing, but we do not want to see any blank cheques issued simply because we have given some sort of benchmark figures.

[15] There is a benefits realisation group operating across the four countries in the UK, and we are part of that. Part of that group's work is to ensure that the potential in 'Agenda for Change' for new working patterns and the modernisation of the health service in general can be achieved through that. Equally, across the four countries, our finance people, along with those in Westminster, Scotland and Northern Ireland, also engage in fairly regular communications to see how things are working out across the UK. So, there is a lot of work going on, but people will appreciate that it would not be the best thing for us to give our best guess of where we are. Clearly, we have some sort of ballpark figures in our heads, but if we start speculating at this stage, when less than 50 per cent of people have been passed over to be fully assimilated, it would not be possible to be accurate, and any figure given, in view of the uncertainty and fluidity, would be a hostage to fortune.

[16] **Jonathan Morgan:** I am happy to accept that response. However, if, at this stage, because of that 50 per cent figure that we are close to, it is difficult to say and therefore to give a benchmark for where the trusts are at and where you think they should be at, at what point do you think that you will be able to give an assessment as to the likely gap? If you are saying that you cannot do it now because it is only at 50 per cent assimilation, at what stage will you be able to say, 'Actually, there is a problem', or, 'No, there is not a problem, because our figures are very close to the figures that the trusts have come up with'?

[17] **Brian Gibbons:** It is fair to say that we realise that the trusts are under pressure—that is not in dispute. The extent of the pressure may be under dispute, and I would certainly say that we will be well into the autumn before we would be able to give some sort of definitive figure, because the margins of error are obviously greater the further you are from fuller

assimilation.

9.40 a.m.

[18] We have pointed out before, in relation to the electronic staff record and a few other issues, that HR departments are under considerable pressure, and are having to keep a couple of very important projects running in parallel, such as the ESR, as well as 'Agenda for Change', but both of those, clearly, are top priorities for HR staff.

[19] **Rhodri Glyn Thomas:** Diolch, Weinidog. Fe symudwn at eitemau 1 i 4. Galwaf ar Helen Mary Jones.

Rhodri Glyn Thomas: Thank you, Minister. We now move on to items 1 to 4. I call on Helen Mary Jones.

[20] **Helen Mary Jones:** I will start with point 1, Chair, on regional reconfiguration. I begin by welcoming the fact that the Minister has extended the initial consultation period, which I think is helpful.

[21] I want to ask the Minister for an explanation of something stated in paragraph 1.4, where he says that the NHS has focused mainly on health issues. I suppose that that is inevitable, but I am somewhat surprised, given the overall commitment to sustainable development, for example, that it has not taken into account some of the wider social, economic and environmental issues that the Minister refers to in his report. I have said before to the Minister that some of the way in which this has been handled has been unhelpful—proposals for change are always uncomfortable, but I do not think that the way in which this has been presented, certainly by the health community in mid and west Wales, has helped in terms of getting the public on board with any of this. I am surprised that it was not asked to address some of those issues, because I would have thought that issues relating to the Wales spatial plan should apply to the whole of the public sector, and it is a bit surprising that a bit of the public sector is going off and doing something when the Minister seems to be telling us that that will have to be revised in the light of a whole load of other things that I would submit they should have looked at in the first place. Can the Minister comment on that process?

[22] I also want to come back on another issue—and this may touch on the plan's wider social and economic implications. I have made the point before to the Minister about having some kind of clear indication in these plans of what the community reprovision that the plans refer to in passing would look like. Obviously, the Minister was right to say that you cannot actually put that provision in place until you have freed up the resources, but if there were a more detailed and costed plan, certainly in mid and west Wales, of what people might get in terms of benefit in community services, they might be more prepared to accept the reconfiguration of hospital services. In the review process that the Minister describes, and the supplementary analysis process in 1.4, is there any capacity to look at some examples of what community reprovision might actually mean for those communities that feel that they are likely to be negatively affected by the hospital reconfiguration? To be quite honest with the Minister, the current proposals are completely unsellable to the public, and unless something is done to make the positives much clearer—and I am prepared to accept that there are positives—certainly, the communities of mid and west Wales, and, I have the impression, some communities in the north, will just not accept this.

[23] **Rhodri Glyn Thomas:** A oes sylwadau eraill ar bwynt 1?

Rhodri Glyn Thomas: Are there any other comments on point 1?

[24] **Jonathan Morgan:** In relation to the process, you say in point 1.3 in the paper, Minister, that the guidance includes any ministerial involvement in the case of a contested process. I am quite interested in exploring the Minister's involvement in the process. First, in terms of a contested process, how is a process contested? Is it merely a matter of the level of

public opposition, or is there a procedure that interested parties must follow to demonstrate that a process is contested? Is it purely about contesting the way in which a consultation was undertaken, or is it really about contesting the outcome of the process that the health boards and trusts have been through?

[25] In terms of the Minister's role, we know, for example, in terms of school closures, that the Minister for Education, Lifelong Learning and Skills has the final say over whether or not a school is closed. What is the Minister's role in terms of the loss of a hospital building? I suspect that there would be very little involvement in reconfiguration, but, in terms of a hospital closure, what is the Minister's role?

[26] **Brian Gibbons:** Some of Helen Mary's questions are difficult from the point of view of the spatial plan. For example, let us suppose that the option to establish a new hospital in Whitland was accepted, while work has already gone on into the possible implications of that for the spatial plan, and the implications of the spatial plan for that proposal, a lot of what will need to be done will depend on the options. So, while a fair amount of discussion has gone on between officials and the people involved in the spatial plan, I do not think that the definitive work-up has been done on every possible option, simply because some of them are quite radical. Let us suppose there was a new Whitland hospital, clearly, work has gone on between leading officials and spatial plan officials on the broad parameters, in relation to issues such as transport, infrastructure, population, effect and so forth. Some preliminary work has already gone on on issues such as those, but nothing definite or exhaustive has happened. It would be disproportionate to do that at this stage. That is trying to convey that, whereas some work has gone on, and this is not going ahead in complete ignorance of the spatial plan, a definitive work-up has not taken place.

[27] On the amount of work that is going on in the health service on sustainable development, like everything else, I suppose, it could be more. However, there is no doubt that all health bodies in the NHS are supposed to be starting to work towards compliance with what is contained in the sustainable development plan—I do not know the word for it is, but it is a big, thick tome, about the size of a telephone directory. Although I would not like it to be the case, it would not surprise me to learn that various people are working with greater or lesser enthusiasm towards that. I have tried to convey to the service in general that I attach importance to that, and I have made a point of trying to attend all the major events in terms of sustainable development. For instance, I went to Bronllys Hospital to highlight its use of photovoltaics. The NHS is such a major employer and big sector in the Welsh economy that its potential contribution to sustainable development is very important. I expect people in the health service to take those messages on board. The fact is that around 90 per cent of energy in the health service comes from renewable sources, which is good progress. The next area that we need to tackle is recycling—not clinical waste, but the ordinary bits of paper, printer cartridges and so on. An awful lot more needs to be done in that area. Once the trusts start getting into using that telephone-book assessment tool, hopefully, further progress will be made. I am pleased enough with the progress that is being made, considering the other demands that are placed on staff in the various trusts.

[28] In terms of building up alternative treatments, I tried to deal with some of those when we had a short debate on the topic last week. I know that you were not at the opening of Tenby Cottage Hospital, but if you had gone, you would have seen some elements of what the future will be like. When we were there, a general surgery clinic and an orthopaedic clinic were being run. There was also a minor injury unit and patients were waiting to be seen. We could not go in to see it, but the x-ray department was also in operation, and an x-ray was being taken of someone's injured foot. That x-ray was captured using the picture, archiving and collection, or PAC, system, and so it could have been sent up to Withybush for an opinion if the nurse practitioner had not been happy with the situation. Down at the other end of the building, there was re-ablement for people who had had strokes or bad arthritis. They

were in to have their occupational and physiotherapy. There was also a citizens' advice bureau office there, though it was not actually in operation when I visited.

9.50 a.m.

[29] In the old system, all of these people would be expecting to go to Withybush in this particular instance, but they can now go to Tenby. Even though we were all milling around, the sense of tranquillity was remarkable; it was less of a cattle fair compared with a district general hospital. For anyone using it, it must be an improved clinical experience, without a doubt. Equally, the hospital is being developed at Pembroke Dock, and I know that the Pembrokeshire and Derwen NHS Trust is in the process of developing its further vision of what the community set-up will be. For example, they are in discussions with their colleagues in the Ceredigion and Mid Wales NHS Trust in relation to what will happen at the Cardigan hospital. They are discussing how that will work with the people in north Pembrokeshire, by having cross-border working there. As Cardigan is more or less on the border, it would not make any sense if people in north Pembrokeshire could not make use of that facility, and if there was no joint development. So, I think that there is good work going on.

[30] I also pointed out that, in Neath Port Talbot, the development of the two primary care resource centres will point the way forward. The problem is that, with the exception of Tenby, nothing is actually visible on the ground, so, to a certain extent, you have to say that it is all happening. It is a bit like up in Blaenau Gwent, where there is a lot of work going on with the railway, clearing the site, building the new hospital, and dualling the Heads of the Valleys road. However, they are not at the stage where people can see what the future looks like, and I realise completely that that is an issue.

[31] **Helen Mary Jones:** Chair, may I come back? I completely accept what you are saying, Minister: there is some good practice in things that are happening and in planning. However, what there is not—certainly across Mid and West Wales, and it may also be true of the north, though I am not as familiar with the situation there—is consistency. No-one expects the health service to put all the re-provision into the community and then to withdraw services from hospitals. That is unrealistic. However, it is realistic for communities to expect to see plans, and you could then point things out and say, 'We will take these services out of this or that hospital, and develop something like what is in Tenby or Neath Port Talbot'. I am not saying that people necessarily need to see physical change in their communities; that would be ideal, but no-one thinks that that is realistic. However, you do not have consistency across the region in Mid and West Wales, and I do not think that you have in the north either. The Pembrokeshire and Derwen NHS Trust may be getting on with its plans for re-provision in the community, and that is great, but I know that Carmarthenshire is not—or at least, if it is, there is no visible sign of it, as it is not consulting local representatives about it. I do not know what is going on in Ceredigion.

[32] Perhaps in the five months between now and the end of the process, leading up to 21 December, I suggest that you, as a Government, try to give a stronger lead to the local health boards and the trusts in those areas. If they are going to ask people to accept change that is necessary, you have to do something to tell them the good news, and there is good news. Tenby hospital is clearly good news, and we are already getting good feedback about that as a positive clinical experience for people. However, there is no consistency of planning, and that was what I was trying to get at. I was not implying that nothing was happening, but there is no consistency across the regions where the opposition is the strongest.

[33] I submit to you—and it is not my job in an election year to make your lives easier—that people are far more likely to accept these plans if they can see them, and can see that they will be positive for the community. This is not completely in your hands, but you can steer and guide LHBs and trusts. I do not necessarily need a further response from the Minister, but

I would urge him in these coming months, when people will be asked to accept some difficult and unpalatable change, to ensure that there will be good news; otherwise, people will just not buy it. It has to be across the board, and not just a few specific good examples—although they could then be used by other trusts and LHBs to say, 'Well, look at what they have been able to do; we could do that if we got the resources out from the hospitals'.

[34] Although there are a lot of pressures on the trusts and LHBs, there seems to be a little time space. You know as well as I do, Minister, that communities across the regions will just not buy this, unless they can see the up side. As I say, it is not my job, as shadow Minister, to dig you out of a hole in an election year, but we want to see some of the outcomes that are intended. We all want to see more services in the community and better clinical standards, and that is what I am getting at. It needs to be across the country, but especially in the two regions that are causing the most concern. People need to hear the good news, and they are just not at the moment.

[35] **Rhodri Glyn Thomas:** Nid oes angen ichi ymateb i hynny, Weinidog, gan eich bod wedi ymateb eisoes. Cododd Jonathan Morgan bwynt am y gair terfynol o ran unrhyw newidiadau neu gau ysbytai.

Rhodri Glyn Thomas: There is no need to respond to that, Minister, as you already have. Jonathan Morgan raised the point on who has the final word as regards any changes to, or closures of, hospitals.

[36] **Brian Gibbons:** The local health boards must develop a lead, and community health councils have to agree to the plans. If the councils are not happy, they have the opportunity to draw up alternative plans, working with the local health board, which they feel will reflect the local situation. If the local health board and the community health council are not able to reach an agreement on the alternatives, it is referred to me for resolution.

[37] **Jonathan Morgan:** To be fair, that did not actually answer the point that I was trying to get at, which was who can contest the process, and is it the—

[38] **Brian Gibbons:** It is the community health council.

[39] **Jonathan Morgan:** So, it is only the community health council that can contest the process. Can it not contest the outcome, only the process?

[40] **Brian Gibbons:** No, it can also contest the outcome. Councils can complain about the process as well as the outcome.

[41] **Jonathan Morgan:** Okay, fine.

[42] **Rhodri Glyn Thomas:** Cymerwn eitemau 2, 3 a 4 yn awr.

Rhodri Glyn Thomas: We will now take items 2, 3 and 4.

[43] **Jonathan Morgan:** I will deal very quickly with points 2 and 3. I welcome the initiative in point 2 and the greater involvement of the voluntary sector. I just want to explore a couple of points. First, you say at the end of point 2.3 that,

'There is substantial voluntary sector involvement in service planning at local level'.

[44] Could you show us the evidence for that, because my experience is that the voluntary sector is usually the last grouping of organisations to be involved in service planning at a local level? I would like an assurance from the Assembly Government that this will be part of an integrated package, and not purely a bolt-on. I am concerned, from recent experiences in Cardiff regarding changes to the mental health framework, that the involvement of the voluntary sector is seen by many as being there to replace the more professional and

experienced staff who work in mental health services in Cardiff. I accept that there is a strong role for the voluntary sector to play, and I welcome that, but I want an assurance that we are not just looking at some sort of cheap fix.

[45] On point 3, I have a couple of concerns in relation to progress on introducing independent prescribing by nurses and pharmacists. This is another development, but I am concerned that it has taken roughly five months since January to establish a task and finish group, and that it may take another 18 months before we get anywhere with the implementation process. That really is in stark contrast to what has happened in England—independent prescribing was introduced there in May, so we are already hugely behind what is happening across the border. In fact, if we assume that nothing will happen until the autumn, or the end of next year, we could be looking at being almost two years behind the implementation of independent prescribing in England, and that is a rather unsatisfactory position for us to be in. Could the Assembly Government explain whether this process could be speeded up? If it is already happening elsewhere, we could learn from experiences in England, although I doubt that the situation there is that different from what is being proposed for Wales. As a result, do we really need a task and finish group to come back 18 months from now with a suggested implementation programme for independent prescribing? I really am concerned about this, and I think that pharmacists in Wales are being dealt a severe blow in comparison with many of their colleagues across the border.

[46] **Lorraine Barrett:** I want to link item 3, independent prescribing, with the introduction of free prescriptions next year, which I welcome. It will make such a difference, particularly to people on multiple prescriptions who are just over the current income threshold for free prescriptions. Will some work be done in the task and finish group, and are you satisfied that the checks and balances will be in place with regard to the possible abuse of the free prescriptions policy, which Jonathan raised in the Chamber yesterday? Some patients may think that the pharmacist or nurse will be a softer touch than the GP, so I hope that they will be trained to the same sort of standard as GPs with regard to saying, ‘No, I am sorry, you cannot have a month’s supply, just because you want it, of paracetamol, Calpol or any another medicine that you can buy over the counter’.

10.00 a.m.

[47] **Helen Mary Jones:** I would briefly like to endorse some of the concerns that Jonathan Morgan has raised about the relationship with the voluntary sector. I would like to ask whether this piece of work will specifically address whether the compact that the Assembly Government has with the voluntary sector is reflected in the relationship that the different health bodies have with the voluntary sectors in their areas, around issues such as three-year funding cycles, core funding for essential services and timetables for consultation. My perception is that that relationship is far from consistent, but I hope that this piece of work will address that. Your report says that the results will be presented in workshops and I would be interested to know who those workshops will target. I also endorse Jonathan Morgan’s concerns about the timetabling of independent prescribing and hope that there is some way in which that can be accelerated.

[48] **Brian Gibbons:** The Wales Council for Voluntary Action research unit needs to be commended on this; it has given us a vast amount of information that we did not have. I was surprised to learn that between £0.25 million and £0.33 million was being used by the health and social care system. The voluntary sector is represented on local health boards and so on. Even though it is not in this document, I think that some of the feedback on this from the voluntary sector spoke of partnership overload. Some of the voluntary sector organisations were involved in up to 100 partnerships in their local health board area and I would agree that that is probably at the extreme end, and that others are struggling to be heard.

[49] Following this, there will be recommendations from the working group as to how things can be improved. Those recommendations will be addressed to the Welsh Assembly Government, the local health boards and the voluntary sector. In one of the areas, the recommendations suggest much greater clarity in relation to how the voluntary sector is involved in the commissioning process. The suggestion is not only for the local health boards to be more willing to engage with the voluntary sector, but for the voluntary sector to not just wait to be called to the table—it has to be a bit more proactive. The voluntary sector organisations also have to recognise that they must link in with the commissioning priorities in their locality. There is no point in providing an absolutely brilliant service, if it is totally unrelated to local commissioning priorities.

[50] The last point is that we have continued to fund the Building Bridges local development workers. That funding will continue for another three years and hopefully one of the workers' big challenges is to create these types of linkages. Some have been quite successful and others have been less successful, but we have made it clear, in the way that the money is to be allocated in this instance, that local health boards will be more actively involved in the process of allocating the money and that consequently better links will be built up between the development workers and the local health boards.

[51] There is a problem with trusts as well. I think that the trusts have not woken up at all to the potential of the voluntary sector. I totally agree with what Jonathan said. I do not think that there is any problem with the voluntary sector being a service provider, but it has to be professional and 100 per cent up-to-scratch in terms of what it is delivering. The fact that it is the voluntary sector does not mean that there should be any easing up on standards or expectations and, in fairness to a lot of the organisations that I meet, that is precisely what they say too. It certainly would not be the expectation of the voluntary sector that it should be providing some sort of cheap, second-class service. That is not its expectation and it certainly would not be acceptable either.

[52] Moving on to point 3, the plan is that this will implemented and will be up and running by autumn of next year, so I do not quite follow this point about 18 months. Hopefully, people going into the training programmes will be starting in approximately March of next year and they will have finished their training and will be ready for action by, as I say, the autumn. Hopefully, that will provide the reassurance that Jonathan was looking for.

[53] Some of the apparent progress that is being made in England has involved some of their extended-role practitioners simply having their titles changed. They are not really doing anything different from what they were doing before. They have just been relabelled as independent prescribing practitioners. For example, extended formulary nurse prescribers in England are now going to be reclassified as independent nurse prescribers, but nothing has really changed. I have seen the media coverage saying that independent nurse prescribing is happening in England but it has just been a redesignation of what is happening. Generally, the feeling is that the level of training—and the task and finish group will clarify this—that our nurses in Wales get for supplementary prescribing is of a much higher level than that in England and the distance that our nurses will have to travel, in many instances, will probably be less than the distance that they will have to travel in England. Lorraine is right, we expect people to work to protocols because, even though this will allow nurses and pharmacists to become independent prescribers, like all clinicians, most will only prescribe within their areas of competence and we would expect, for example, pharmacists to be involved in some sort of minor illness scheme or nurses to be involved in such a scheme within the practice and to be prescribing in that area of competence; we would not expect a nurse or a pharmacist to start prescribing anti-cancer drugs simply because they have the legal power to do so, because that would be totally unprofessional and unethical. The same is true of doctors: they only prescribe within their areas of competence. They have the legal power to prescribe anything

that they want, but if you prescribe outside of your area of legal competence, you are in trouble and the patient is potentially in trouble. So, the same thing will apply to nurses and pharmacists. If pharmacists want to issue Calpol to children, as an independent prescriber, we would expect that they would have the training and competence and protocols in place to do that.

[54] **Rhodri Glyn Thomas:** Jonathan, a oes gennych sylw ar bwynt 3?

Rhodri Glyn Thomas: Jonathan, do you have a comment on point 3?

[55] **Jonathan Morgan:** I have a very quick response to that. I just wanted an assurance that we have not lagged behind any development elsewhere in the UK and that we will not be lagging behind the implementation. If the introduction of independent prescribing by nurses and pharmacists in Wales is happening elsewhere, I do not see why we should face the prospect of not implementing it at the same time. I think that it is only fair to pharmacists and nurses in Wales that they have that opportunity as quickly as possible.

[56] I echo the concern that Lorraine raised about medicine wastage and how pharmacists and nurses are advised of their duties. Often, a pharmacist working in a small village may have a closer relationship, socially—through family connections and so on—with people living in that village than perhaps the GP, and that needs to be explored, particularly, as I mentioned yesterday, when we end up having prescriptions that are free.

[57] **Brian Gibbons:** I think that pharmacists involved in any of this will have to have provision for confidentiality. You are not going to be engaging in a discussion with the patient across the shop counter. If you want to be involved, you have to have provision for confidentiality.

[58] **Rhodri Glyn Thomas:** A oes sylwadau ar bwyntiau 5, 6 neu 7?

Rhodri Glyn Thomas: Are there any comments on 5, 6 or 7?

10.10 a.m.

[59] **Helen Mary Jones:** On point 7, the European working time directive, I think that this is quite worrying. This is not the first time that I have talked to the Minister about this. I have to be honest, I have not said it as strongly as this before, but given the length of lead-in time we have had for this, I think that our being in this situation at this point is a serious failure. I do not know whether it is a failure on the part of the Government, the service, or whatever. That said, we are where we are. I would like to ask the Minister a few things in relation to this. You give us the figures here about regional compliance, and it is interesting that that is quite variable. Are the figures available trust by trust? Are there serious differences? Is that information that you would be prepared to share with the committee in a written paper? What analysis have you done as a Government about which trusts are worse and why? What will you put into place to deal with them? Have you done any analysis of the impact that any action that trusts are taking to address deficits? We know that some trusts are freezing posts, though we have not yet faced redundancies, thank goodness—I emphasise that that is as yet. However, we know that some trusts are freezing posts, so have you made, or will you make, an assessment with individual trusts about how action to address deficits may make it more difficult for some trusts to comply with the working-time directive?

[60] I would like to ask the Minister for clarification on the implementation and possible consequences. If we get to the point where, heaven forbid, fines are being imposed—and we hope very much that that does not happen—who will face the fines? Will it be the Assembly Government, or will it be the individual NHS organisation? Finally, and this may be a slightly cynical point, Chair, have you made any assessment of how real the threat of fines is? Is the European Commission likely to target British health organisations? I suppose that I am

slightly sceptical given that the European Commission does not always enforce its laws very rigorously and given the bad publicity it would have if it started taking money out of front-line NHS provision to pay for fines. I wonder what assessment the Minister has made. He may, given his responsible position, feel that he should not answer that point, but I think that in terms of the action to address this, there needs to be some kind of risk assessment about how real the risk is of getting into serious trouble.

[61] I would like to finish by putting this in context. We all know that this is the right thing to do, rather than continuing with the old practice of young doctors working God knows what hours. I do not think that any of us would want ourselves or members of our families to be treated by someone who had been working for 36 hours. So, none of what I am saying is in any way to suggest that we should not be implementing the European working time directive; it is just exasperation that it is taking so long, and to ask, now that we are getting to the deadline, how we will cope if there are inabilities to comply—not a refusal, but an inability to comply.

[62] **Jonathan Morgan:** I have two quick questions. First, what steps are you and your department taking not only to ensure compliance, but to help the NHS trusts to reach compliance, because this is not just something that they have to solve; this is something that is being imposed as a result of the negotiations between the UK Government and the original 15 member states prior to enlargement. This is a serious issue because they are legally obliged to comply. We know, as the Chair and I both sit on the European and External Affairs Committee, that the likelihood of an early set of fines coming from the European Court of Justice is rather limited. I can assure you that there will be a number of other European countries where compliance will be lower—as per usual probably mostly France, Germany and Italy, where the levels of compliance are traditionally far lower than the UK levels of compliance with EU directives and regulations. Having said that, there is a legal requirement. However, I would like to know what the department is doing to help the trusts to achieve this, because it should be a shared problem, not just something that the trusts do on their own.

[63] Secondly, have you spoken to your colleagues at the Department of Health in England to establish what steps are being taken either in England or elsewhere in the European Union, because this is a problem now being faced by 25 countries, not just Wales?

[64] **Brian Gibbons:** I am not too sure that I would agree with Helen Mary in relation to the question of serious failure. The first line shows that current compliance is 95.5 per cent. I think that getting to 95.5 per cent has been a tremendous achievement. Anyone who has been out of the health service over the last five years may be slightly iffy as to whether or not we would even have got to 95.5 per cent. That is not a badge of failure; it is a badge of achievement. There is no doubt that the residual requirement to get to the 48 hours is a massive challenge. Just to get to that 95.5 per cent has required massive changes in the way that our hospital services work. So, getting to the 48 hours will require similar massive changes. This is one of the big drivers behind ‘Designed for Life’, and it answers the question why ‘Designed for Life’ has been hospital frontloaded. One of the reasons that it is hospital frontloaded is precisely because of the requirements of the working times directive. Many of the other changes in ‘Designed for Life’ could be introduced, possibly, over a longer period of time and in a more phased way. However, we cannot ignore 2009 and it places certain imperatives upon us and demands a certain speed of change—in other circumstances, possibly, we would not be going as vigorously towards achieving it. This will not just be change within hospitals; it has to be change between hospitals. That is why ‘Designed for Life’, as well as reasons for clinical governance, keeping the system going and complying with the working times directives, is a big driver of ‘Designed for Life’ and its predecessor, ‘Designed for Care’.

[65] Most of the junior posts that are involved in these rotas are training posts. We

separately fund these training posts—they are funded, by and large, through 'Wales: A Better Country', which is part of our general manifesto commitments. We will continue to fund that, and hopefully, fund it sufficiently to make sure that everyone who comes out of medical schools in Wales will have the option of getting onto a training programme. We are not totally masters of our own destiny in that, because there are open borders across to England, but we certainly hope to be doing our bit.

[66] The 'Designed to Comply' document, which we will circulate if you have not already had it, goes through it trust by trust. It includes bits of regional commentary and I am doing a written statement on it later in the week. We would be happy to come back to this in some way if committee members want to do so, because this is a big issue that can improve the quality of care and the working conditions of staff within the NHS. However, it puts fundamental challenges to the NHS in terms of how it goes about its business.

[67] I do not want to comment on how the realistic the risks of fines are, but there is also the option of jailing trust chief executives. I will not comment on either issue.

[68] In terms of involvement, there is a special working times group—I cannot remember its title—which is led by junior hospital doctors on secondment from the NHS. The group has been in operation for a number of years, and it continues to be in operation. Reference is made to the group in the introduction to 'Designed to Comply'. The group has been at the forefront in developing such things as hospital at night, which is a key part of delivering compliance. We are working very closely with the Department of Health in England in trying to share experience. A lot of what we are doing is common practice across England and Wales.

[69] **Rhodri Glyn Thomas:** A oes unrhyw sylwadau ar eitemau 8, 9 a 10? Helen Mary?

Rhodri Glyn Thomas: Are there any comments on items 8, 9 and 10? Helen Mary?

[70] **Helen Mary Jones:** On item number 10 about the new World Health Organisation child growth standards, I would like to emphasise what I believe to be the seriousness of this. We know that the previous growth standards were based on the rate at which bottle-fed babies put on weight.

10.20 a.m.

[71] We know that the World Health Organisation has apologised for that, because many mothers may have been concerned that their breast-fed babies were not putting on weight fast enough and may have stopped. All of us, through friends and family and so on, probably have anecdotal evidence of that happening. Therefore, if this is an issue of sufficient seriousness to get an organisation like the WHO apologising for its error, and given the emphasis that the National Assembly Government is quite rightly putting on promoting breastfeeding, I am a little concerned that there is not more urgency in the response to the question that I raised with the Minister.

[72] The report says that discussions will be taking place during the summer. Will the Minister tell us a bit more about who will be having those discussions and how soon we can expect the outcome of those discussions? The fact is that, while we may be having these discussions, and while the WHO has apologised, mothers who are breastfeeding their babies are still having the growth of their babies assessed against inappropriate charts. We know that it can be a very difficult decision, especially if there is no family tradition of breastfeeding and so on, and we know the benefits of breastfeeding for children. I suppose, therefore, that I am hoping that I can inject a little urgency into the Minister's and the Government's response to this. I press him for a commitment on the introduction of weight and height growth

assessments based on the new WHO charts, but if he does not feel able to give that commitment today, will he tell me when we can expect the outcome of those discussions during the summer to come to fruition? I also ask him to report back to committee once we know that whoever is having those discussions is recommending the introduction of new growth standards.

[73] **Lynne Neagle:** I share many of Helen Mary Jones's concerns on this. Anyone who has breastfed a baby would have been worried when we heard the news of the WHO's announcement. It is important that all parents are able to take assurance from the charts that their child is measured on. I seek some clarification. Point 10.2 states that these charts are not being used in Wales yet. Are they being used elsewhere in the UK, or is that the way it has been worded?

[74] **Brian Gibbons:** We will have to get some more information on this. I asked for this to be included in the Minister's report, in conjunction with the work that we are trying to do to promote breastfeeding, and I wanted to give a flavour of the holistic approach that we are taking. On the specific items that both Lynne and Helen Mary have raised, we will have to give a written note to committee members to update you on that, or maybe even a paper expanding it out in more detail. As I say, it was part of the work that we are doing on breastfeeding to try to underpin why that work is important. I saw something during the week which was also concerning in all of this. Generally, babies born in Wales are among the smallest in the United Kingdom and, by the time they are a year old, they are probably some of the most overweight in the United Kingdom. If we accept that a lot of people's future life prospects are programmed in utero, that suggests the importance of the approach that we took in our children and young people's national service framework, which covered maternity services as well. That strategic decision to cover maternity services as part of the children and young people's national service framework was a very wise decision, borne out by the discussion that we are having now.

[75] **Lynne Neagle:** On point 8, on the MMR catch-up campaign, it is obviously very welcome news that the campaign has been very successful with young adults, but I wondered whether the Minister could give an update on what the uptake figures for babies were looking like and what steps the Assembly Government is taking to promote the uptake.

[76] **Brian Gibbons:** I do not have the figures, but there is no doubt that, from the low point of 12 or 18 months ago, the uptake is improving. However, it is certainly well away from the 95 per cent that we are aiming to achieve. It has been bottomed out in terms of the decline in uptake, but not anything like we would want to see. We continue to promote MMR as something that is very important. There is also the fact that we had a large increase in the number of mumps infections, which we have outlined there. I asked for a breakdown of measles cases; while there have been some good years with regard to measles, in 2003, there were 44 cases. Measles is a potentially fatal condition, and even if children do not die, they run the risk of pretty serious complications in terms of deafness, brain damage, visual handicap and so on. Therefore, getting the immunisation rate up is an important public health priority.

[77] **Lynne Neagle:** Can we have a note on the figures and what recent steps have been taken to boost uptake?

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

[79] **Rhodri Glyn Thomas:** Trown yn awr at bwyntiau 11 hyd 14.

Rhodri Glyn Thomas: We will now turn to points 11 to 14.

[80] **Jonathan Morgan:** Very quickly, on point 12, in relation to the oxygen contract, you

said that officials have been meeting Air Products to ensure tight deadlines to enable the company to meet its targets. You also said that you expect the withdrawal of pharmacies by the end of this month. Can we have a brief report, perhaps in the autumn, outlining how Air Products has managed to meet those targets? I accept that there is no point in doing it at the moment until we know how it will operate once the pharmacies withdraw from providing assistance, this month, but perhaps, by the autumn, we can re-examine this matter and then see whether the service is working effectively.

[81] **Helen Mary Jones:** Further to that point, 12.3 says that the aim of the exercise is to ensure that all patients have been identified by the beginning of July and assimilated by Air Products by the end of the month. We have had many aims in this process, and I wish to press the Minister on how confident he is that that aim will actually be met. I also seek an assurance from him—although I think he has implied it in the report, I would like to pick out—that, should that aim not be met, patients will still be able to receive their oxygen supplies through the community pharmacists that are providing them now. I can quite see why you would need to set a deadline, because otherwise things do not get met, but there is some concern. The matter certainly has been raised with me by constituents who are directly affected who say, ‘This aim is fine, but what if it does not happen—will I still be able to get my oxygen from my community pharmacist?’.

[82] I have a specific question on 13, Chair. Do you want me to ask that now? I am pleased that, in point 13.2, the Minister says that the deliveries will be completed by the end of September 2006, and that arrangements will then be made to bring them into Wales. Can I press the Minister on what the timescale will be for bringing them into Wales? If we start making the arrangements in September, when will they actually be here? I also seek clarification. My understanding is that these drugs are only effective within a very specific period of infection. Does that influence where the drugs should be stored? If, heaven forbid, there should be a serious outbreak, one would think that those drugs must reach any infected communities within a matter of hours. Is it the intention to store the anti-virals in one place in Wales, or will we have several locations so that stocks can reach communities quickly, bearing in mind the rigours of our transport system?

[83] **Brian Gibbons:** The number of people available, as you can see from the paper, is nearly 7,500, which is far higher than the original estimates of the number of people who we thought were on oxygen. The feeling is that we have got virtually everyone identified. There will be a few people who are on very intermittent oxygen who have not presented themselves to the system yet, so there will certainly be a few people out there. I feel a bit like Donald Rumsfeld saying this, but we know what we know, and we do not know what we do not know. So, in terms of the unknowns that are out there, clearly, until they become known, we do not know how many unknowns there are. However, we are fairly confident that Air Products is now covering the overwhelming majority of these people.

10.30 a.m.

[84] There are some problems with patients on ambulatory cylinders, because there has been a dramatic increase in the number of people availing themselves of ambulatory cylinders, which were not generally available to any great extent in the past. There has been, from the patients’ point of view, a welcome uptake. We are not sure whether or not people have been piling them in their homes, because they were burned by the start of this particular process. In fairness to Air Products, it has ordered 10,000, 15,000 or 20,000 extra cylinders to try to cope with that demand. It has also doubled the number of delivery staff whom it has put in place to meet the demand. However, we will not withdraw the capacity to prescribe oxygen on the ordinary prescription for the foreseeable future, so there will be a safety net just to be sure, even though we are fairly confident that, by the end of July, Air Products will take full responsibility for the oxygen. We will try to provide a definitive report then, which may be a

paper to note, and if people want to raise questions, if they give us notice, and with the permission of the Chair, we can try to do that.

[85] Hopefully, our residual requirements for the flu anti-viral drugs will be in place by September, so that they will all physically be in Wales by then. I do not think that the storage requirements are very demanding, but we would like them to be in regular, secure locations that are linked, wherever possible, to existing pharmaceutical practices. Helen Mary is right in saying that the infectivity of the virus can be reduced if the anti-viral drug is given early enough during the illness. So, the potential of the infected person spreading the virus decreases if you get in within the first, I think, four to six hours. To get the benefit in terms of hospital admissions and so forth, you have another 24 to 36 hours to make a difference. We are holding pilot schemes in Rhondda Cynon Taf, which are mainly trying to test what the distribution mechanism would be in the event of a flu pandemic. The experience of this trial exercise in Rhondda Cynon Taf will be the basis for the distribution exercise at the local health board level. I am trying to read Tony's note here, but this is doctor's writing.

[86] **Rhodri Glyn Thomas:** Dylai Tony ei hun ddarllen ei nodyn.

Rhodri Glyn Thomas: Tony himself should read his note.

[87] **Dr Jewell:** At the moment, the anti-virals are stored at one site in Wales. We have identified other sites to assist with distribution when the levels change. As the Minister says, the local distribution to get anti-virals to people who may be advised to stay at home is a logistical problem that we are exploring in RCT with logistic companies that are used to delivering to homes in a rapid way, because, as the Minister said, they have to be delivered, preferably within 24 hours, but certainly within 48 hours. So, that work is currently under way.

[88] **Lynne Neagle:** I wanted to raise the issue of bone marrow transplants. I spoke to you yesterday, Brian; it was agreed that we would have an update on the bone marrow transplant waiting list situation, but it is not in the report. I am worried, because it is a pressing concern, and we will not meet again until the end of September. I do not know whether you are in a position to give some sort of oral report on it today.

[89] **Helen Mary Jones:** I have a separate matter; do you want me to raise it now? It is not in the report and it is a different matter.

[90] **Brian Gibbons:** In relation to the bone marrow transplant issue, we have agreed—'we' being Health Commission Wales—with Cardiff and Vale NHS Trust on the necessary funding to provide 86 transplants this year, which is what was effectively provided last year. We must accept that 86 transplants are not enough to meet the demand, so there are ongoing discussions on the fact that, as well as guaranteeing last year's output, we will try to create further capacity. Discussions are going on between Health Commission Wales and Cardiff and Vale NHS Trust as to the type of money that is needed and how the service must be reconfigured to deliver that. Those are active discussions that are going on, and while it would be rash to pre-empt an agreement, I get the feeling that the discussions are going forward in a positive way and that some sort of progress will be reported. If further agreement can be achieved, hopefully that will be enough, initially, to stabilise the waiting list, in that they will not get any longer, and then to start to cut into them gradually.

[91] The median wait—in other words, the 50 per cent wait on the spectrum—is 99 days. That means that the more urgent patients on the waiting list are seen in less than 99 days. I think that everyone agrees that that period is too long, and that it is something that needs to be improved upon. However, 99 days gives us a benchmark in terms of the length of wait for some people. One of the problems with bone marrow transplants is that some people hit the system in an urgent way, and those people must be put at the top of the list on the basis of

their clinical requirements. So, it is a difficult list to manage. There is a small amount of work going on elsewhere in Swansea and north Wales, but the great bulk of it is being delivered through Cardiff and Vale NHS Trust.

[92] **Lynne Neagle:** I thank the Minister for the update and the assurances that the situation will not get any worse. However, we want to see the situation improving dramatically and quickly. While I accept that you say that the average wait is 99 days, the constituent about whom I have written to you has been advised by his consultant that he will, potentially, be waiting for some 14 months for treatment, which is very worrying given the severity of the illness. How does this type of waiting time fit with the cancer targets for the period between diagnosis and treatment? Presumably, a bone marrow transplant is considered to be a part of the treatment, albeit a secondary part, after chemotherapy or whatever, but it seems that we are seriously in breach of that target. There are difficulties with capacity in Cardiff and Vale NHS Trust, but what consideration is being given to commissioning these operations elsewhere in the UK, as we have done with the second-offer guarantee for other conditions, which, although very painful, are nevertheless less serious than the cancer that these patients live with?

[93] **Brian Gibbons:** I do not think that bone marrow transplants are covered by the target, because, as Lynne said, it is very rare that a bone marrow transplant is the first line of treatment. Theoretically, if it were the first line of treatment, it could conceivably be covered by the target, but it is usually something that comes into the treatment plan at a later stage. I do not think that we have done a lot of work on looking at a second-offer scheme—I think that all the work is going into try to get a sustainable service in Wales. We know from the Wales Audit Office reports, and so forth, that the second-offer scheme is generally more expensive and would militate against creating a sustainable service in Cardiff. However, I accept the point that you make, and we could look at that to see what opportunities are there. We must also remember that, if you have your hip done, and there are no complications, the job is done, but when people have bone marrow transplants and other underlying malignancies, it is not comparable to the type of procedures that are done on the second-offer scheme. Clinically, it is in a completely different field to having your hip done or even having coronary bypass surgery when, hopefully, the job is done and the follow-up is fairly routine, whereas, for the patients who would be having bone marrow transplants, the follow-up would be anything but routine. Without having looked at it in any detail, I suspect that that would be a fairly important consideration. I do not know whether Tony has any off-the-cuff remarks to make.

10.40 a.m.

[94] **Dr Jewell:** I agree with the Minister. It is part of the management of the condition, so it needs to be seen as long-term management and this is just one part of it. It is quite unlike elective surgical operations and they are being treated as part of a team, so I think that the way forward is to look at our capacity in Wales to see how we can meet the need.

[95] **Lynne Neagle:** Could I ask for there to be a further detailed update on this at the first meeting after recess?

[96] **Rhodri Glyn Thomas:** Mae'r cais wedi ei gofnodi.

Rhodri Glyn Thomas: The request has been noted.

[97] **Helen Mary Jones:** My comment is on an additional matter, Chair, that I understood would be in the Minister's report, but is not. In the meeting on 15 June, I raised the issue of funding for the Wales Neuromuscular Network, and the record of that meeting shows that the Minister agreed to give an update on it. This is an urgent matter because the funding for the network comes to an end on 31 July. The representations that have been made to me, and to

others, assert that the network is not sustainable without some Government funding.

[98] I understand that the Minister has received correspondence on this from some of the clinicians, therapists and patients who might be affected if the network had to cease to operate. Could the Minister say anything on this matter today? I did understand, although I may have misunderstood, that there was some acceptance on 15 June that this matter might need a second look. Could the Minister say anything further about that today? If he cannot, could he give us a note on it? The work that the neuromuscular network does is valuable, and I think that the Minister acknowledged that when we met on 15 June. It would be a great shame for that service to be lost at a time when the Government is trying to encourage more clinical networking and co-working within specialities. I do not know, Chair, whether the Minister can say any more on that today or whether the right thing would be to receive a note from him on this matter. However, I would like to put on record my concern that we will lose something very valuable in Wales, if the network ceases to operate on 31 July.

[99] **Brian Gibbons:** We acknowledge that the network is doing a good job, but we certainly do not see this as a responsibility for central funding. We, as an Assembly Government, centrally fund a rather limited range of services, and direct support to the network is not regarded as being part of our central responsibilities. It has to be part of the general commissioning of services and support services in the health service, as is the case for virtually all the networks that operate, be they cardiac networks or cancer networks. We do not really support those centrally; they have to be supported out there. We give them some help from time to time, but the main stream of support is out there in the health service; they are not centrally funded. That is the position that we have taken on this issue. I would certainly be pleased to provide Helen Mary with a further update in the autumn. I have pointed out to the people who have written to me on this issue that the network is not something that we feel is a responsibility of central Government.

[100] **Helen Mary Jones:** I am not going to argue about whether it is a responsibility of central Government or not because that is for the Minister to determine, up to a point. However, if you are not able to continue this funding, because it is my understanding that the funding comes from you at the moment, will you give an undertaking to get your department to work with the other commissioners to see whether there is any way in which resources can be provided in whatever the usual method may be, by the people who commission services, to ensure that the network does not collapse? If you do not think that it is your job to fund the network, but you think that it ought to survive, it is clearly someone’s job to fund it. Would it be possible for the department to intervene at that level, if it is not possible for the funding to be continued?

[101] **Brian Gibbons:** We can certainly bring back a paper. We have heard what you have said on that, and we can try to bring something back on it. However, I do not want to be offering people unrealistic hopes and expectations.

[102] **Jonathan Morgan:** I want to raise a very quick issue. It is not contained in the paper, but, during the last week, the UK Government has confirmed that it will cease recruiting foreign nurses from outside the EU and, as a result, the Home Office will be removing the occupation as a shortage occupation from its list. What policy or practical implications, or both, will that have for us in Wales. I was not sure whether this was a devolved matter for us or whether, because of the involvement of the Home Office, it was a UK matter. In Wales, and particularly in Cardiff, we have a proud history of providing posts to nurses from outside the EU and they have made a valuable contribution, and I was wondering what the implication of this was for us in Wales. I know that we have seen quite a substantial increase in agency nursing costs since 1999 and we are training larger numbers of nurses. Could the Government clarify what the position is for us here?

[103] **Brian Gibbons:** This is not a devolved matter. Clearly, we are bound by the Home Office, and its judgment on this compared just as well here as it did in England. If people apply for a job in the normal run of events, and they comply with visa requirements, they are clearly on a level playing field with everyone else. However, the situation that we were in a few years ago, when we were going overseas and actively recruiting people to come to work in the national health service, will finish, because we feel that the number of people in training in the national health service, for nursing and other professions, is more than adequate to meet our needs in the main. There may be a few specialist areas where we may have a slightly different attitude, but we would not expect to have to go overseas for the mainstream areas. However, if people are resident in this country, who are entitled to be here on the same basis as everyone else, and who have work permits, there will be no discrimination or anything like that against them. They are working on a level playing field. However, we will not be doing active recruitment.

[104] **Rhodri Glyn Thomas:** As we are facing the recess, and we will not be meeting again until we reconvene in September, there are a number of issues on which Members want clarification. I note that there is not an update about the tertiary autism services in Cardiff, though you promised to report back to committee if there were any changes. Is that situation ongoing in terms of funding, and will it be ongoing until September?

[105] **Brian Gibbons:** We—that is, the local health boards—have extended funding to the Cardiff and Vale NHS Trust for another three months. The work of profiling what is going on at the Cardiff and Vale trust is continuing. To a certain extent, the service is in limbo because the lead clinician is not at work at the moment, which makes the situation even more fluid from that point of view. We are not in a position to give a definitive answer, because the work is still ongoing in profiling the need and in looking at the other options of developing networks outside Cardiff, which is one of the issues. Is the use of Cardiff as a consequence of a need for a tertiary service or is it because of the absence of the service in the locality from where people are coming? If there is anything definitive, we will be in a position to do that, but we are not in that position at present.

[106] **Rhodri Glyn Thomas:** Thank you, Minister. To be fair to Dr Piggot, I understand that she is on maternity leave at present.

[107] Symudwn ymlaen at eitem 3.

We will move on to item 3.

10.49 a.m.

Rhestr o Is-ddeddfwriaeth
Schedule of Secondary Legislation

[108] **Rhodri Glyn Thomas:** Mae'r eitemau newydd wedi'u cysgodi. A oes rhywun am ddwyn sylw'r pwyllgor at unrhyw faterion?

Rhodri Glyn Thomas: The new additions have been shaded. Does anyone want to draw the committee's attention to any matters?

[109] **Helen Mary Jones:** On page 14, item HSS 25 (06), there are the Placement of Children (Wales) Regulations 2007, and I think that we should take a look at those, along with HSS 28 (06), the National Health Service Act 1977 Primary Care Trust Dental Services Directions 2006.

10.50 a.m.

[110] **Rhodri Glyn Thomas:** A ydyw pawb yn hapus â hynny? Gwelaf eich bod.

Rhodri Glyn Thomas: Is everyone happy with that? I see that you are.

[111] **Jonathan Morgan:** I certainly support both of those suggestions.

[112] **Brian Gibbons:** I have just had a note from one of my officials drawing the committee's attention—though I am not sure where it fits in—to the National Health Service (General Ophthalmic Services) (Amendment) (Wales) Regulations 2006 with regard to the timetable of our forthcoming legislation. They were to be made by executive procedure. However, these are now likely to go through the standard procedure. I have been through the table, but I could not quite find them. Perhaps Jane knows the specific reference number.

[113] **Rhodri Glyn Thomas:** It is No. 29, Minister.

[114] **Brian Gibbons:** Okay. I just wanted to give you that information.

[115] **Rhodri Glyn Thomas:** Os nad oes dim byd arall, symudwn at eitem 4.

Rhodri Glyn Thomas: If there is nothing else, we will move on to item 4.

10.51 a.m.

Is-ddeddfwriaeth: Diwygio Rheoliadau Gofal Cymunedol (Gwasanaethau ar gyfer Gofalwyr a Gwasanaethau Plant) (Taliadau Uniongyrchol) (Cymru) 2006
Secondary Legislation: the Community Care (Services for Carers and Children's Services) (Direct Payments) (Wales) Amendment Regulations 2006

[116] **Rhodri Glyn Thomas:** Nid oes gwelliannau wedi'u cynnig, ond mae dau bwynt o eglurhad ar bapur 3b. Helen Mary, a ydych yn hapus i'w cyflwyno fel ag y maent?

Rhodri Glyn Thomas: No amendments have been proposed, but there are two points of clarification on paper 3b. Helen Mary, are you happy to present them as they are?

[117] **Helen Mary Jones:** Ydwyf.

Helen Mary Jones: Yes.

[118] **Brian Gibbons:** I think that we went into some of these issues in great detail when we had the previous scrutiny session, dealing with the first one. When the scheme was announced, some £90,000 was made available to local authorities across Wales to promote this scheme and to make the information available. As part of any assessment process—and more so after these regulations—and of sharing the conclusions with service users, the option of direct payments should be raised, even though there is a fair amount of information out there in the form of leaflets, booklets, DVDs, CD-ROMs and so on. In the individual situation, the possibility of going down the direct payments route should be routinely raised with users, and explained to them. There are several support agencies like the Gwent Association of Voluntary Organisations, the Shaw Trust, and the Rhondda Cynon Taf National Centre for Independent Living, which are operating to give support. You will be aware—and I think that it is mentioned in the supporting documentation—that we are providing something in the order of £800,000 to support this further. That is a massive investment in the support infrastructure for independent living. That is not money going into the coffers for direct payments, but it is to put in place the infrastructure and the people at a local level to allow this to happen. That is on top of the money that is already in the system. The amount of money that we are making available to the direct payment schemes is substantial and will provide the necessary capacity to publicise it fully and to make information available at a local level.

[119] **Helen Mary Jones:** Thank you for that. I would like to push you slightly. You said in your response that the option of direct payments should always be raised. I think that the experience on the ground is that that is not always the case, and particularly so perhaps with

regard to children. What are you doing on this? Presumably, it is the job of the Social Services Inspectorate for Wales to ensure that that is raised. It may be something that many families or people do not want, but it should be offered as an option. It has been put to me that that is not routinely the case in all counties.

[120] Secondly, what have you done, or what would you be prepared to do, to assess the information that is available, particularly in minority languages other than English and Welsh? It has been suggested to me that it may be particularly appropriate for some people from ethnic minority communities to use direct payments, because they can then make sure that they are getting culturally appropriate care, which may not be easy to get with mainstream services. What assessment have you made of how counties are using the promotional opportunities that you are making available to them to ensure that those communities in particular get that information? We know that people from minority communities tend to under-use public services and under-access entitlements in quite a big way, so, if you have not yet been able to look at that with the appropriate county council, I would press you to do so.

[121] **Brian Gibbons:** I think that we have dealt with some of that. I said that direct payments ‘should’ always be raised, but it was just that there are, obviously, some emergency situations. I think that the ‘should’ should be read as ‘could’ or ‘will’, excepting where common sense dictates otherwise.

[122] **Helen Mary Jones:** Common sense in the provision of social services can be slightly dangerous. I am sure that you did not mean that, Minister, but I can think of circumstances in which someone might say, ‘This child is so profoundly disabled that common sense dictates that he or she will not be able to cope with direct payments’.

[123] **Brian Gibbons:** No.

[124] **Helen Mary Jones:** I know that you did not mean that, but now that we have a verbatim record, we have to be very careful.

[125] **Brian Gibbons:** You are quite right on the interpretation. However, in that context, we have also tried to make information available in British Sign Language, large print, audio and so forth. I know that, in Cardiff, information is available in Urdu, Somali, and Hindi as well as English and Welsh—as the expectation would be. As I said, the level of resource that goes in to underpin this is substantial, and I do not think that there could be much excuse for any local authority not really to make a serious effort to make this information universally available in their communities. I am sure that you are right; direct payments would be far more suitable as a way of providing care to certain groups than the standard package perhaps, on cultural and religious grounds.

[126] **Rhodri Glyn Thomas:** Diolch yn fawr, Weinidog. Torrwn am egwyl yn awr.

Rhodri Glyn Thomas: Thank you very much, Minister. We will now take a break.

Gohiriwyd y cyfarfod rhwng 10.57 a.m. a 11.12 a.m.
The meeting adjourned between 10.57 a.m. and 11.12 a.m.

Y Mesur Diwygio Deddfwriaethol a Rheoli
The Legislative and Regulatory Reform Bill

[127] **Rhodri Glyn Thomas:** Yr ydym wedi derbyn gohebiaeth oddi wrth Gadeirydd y Pwyllgor Busnes yn gofyn inni edrych ar y

Rhodri Glyn Thomas: We have received correspondence from the Chair of the Business Committee requesting that we look

Mesur hwn—yn nghyd-destun iechyd a gwasanaethau cymdeithasol, wrth reswm. A oes gan unrhyw un sylwadau ar y Mesur hwn?

at this Bill—within the context of health and social services, obviously. Does anyone have any comments on this Bill?

[128] **Helen Mary Jones:** The struggle to understand it and its implications is a bit of a task. However, at a fairly superficial level—so the Minister will no doubt correct me if I am wrong, or he will find someone else who will correct me if I am wrong—the concern is about whether this measure would give Ministers at Westminster plenary powers that would enable them to undevolve things. People have said silly things like it would enable them to abolish the Assembly; I do not think that that is true, but will the Minister tell us whether he and his officials have been able to make any assessment of what it might entail? We have seen—and most of us have welcomed it—a gradual increase in specific devolution of health and social care matters in measures that have enabled the Assembly to do things in a different way, and we would all have a real concern if this legislation created any capacity—and I am not, at this stage, Chair, suggesting that there would be a will to do this—for Ministers at Westminster, perhaps under a future regime, were they so minded, to roll things back. Also, has any assessment been made of how the new Government of Wales Bill would impact on any implications of this Act? Forgive me for the questions being very broad, but it has been quite difficult to get one's head around.

[129] **Jonathan Morgan:** I have a similar point and question. Those of us in the Assembly—and I suspect that it is an overwhelming number of us—have welcomed the greater devolution of power with regard to health and social services, contrary to what my very good friend, the Member of Parliament for Monmouthshire, would like to see.

[130] **Helen Mary Jones:** Bless his heart.

[131] **Jonathan Morgan:** Indeed. I, for one, have been supportive of the fact that the Assembly has a huge devolved remit, and that, apart from a few bits and pieces, we have a huge say—almost an exclusive say—over health and social services matters. However, one issue that concerned and rather confused me is, if we consider the passage of the Government of Wales Bill through the House of Commons and the House of Lords, how has that been examined with regard to the clauses contained within the Legislative and Regulatory Reform Bill. One of the concerns expressed by lawyers at Westminster was that one could potentially have an impact on the other. Therefore, in a new Government of Wales Act, we could end up, perhaps, with it not being what we envisaged when we started out. It is that level of confusion and concern that exists, and I suspect that it is not only in relation to Wales, but also, probably, in relation to Scotland and Northern Ireland. From our perspective as the Health and Social Services Committee, what will be the level of assessment from the Office of the Counsel General in advising the Department for Health and Social Services of what potential impact this Act could have, once it passes through the stages?

[132] **Rhodri Glyn Thomas:** A oes unrhyw sylwadau eraill? Gwelaf nad oes. Weinidog, medrwch ein goleuo ynglŷn â beth yn union mae'r Mesur hwn yn bwriadu ei gyflawni.

Rhodri Glyn Thomas: Are there any more comments? I see that there are none. Minister, you can enlighten us as to what this measure aims to achieve.

[133] **Brian Gibbons:** I am certainly flattered to be up at the oche for this one. On Helen Mary's point, I think that carrying the logic of some of this to the point of absurdity is theoretically possible. However, I doubt that you could say that abolishing the Assembly on a whim is a non-controversial matter, and it would probably fail on that test, and, consequently, would not be competent under this. What is more important, to be honest, are the implications for Ministers post 2007, because our status as Ministers of the Crown will be no different

from Ministers of the Crown in Westminster, I presume.

[134] My understanding of this is limited, so I will not pretend to give a definitive answer, but I understand that when there are two pieces of legislation going forward on this basis, and particularly when the Government of Wales Bill is more than likely to become an Act, then the following-on piece of legislation, which is the Legislative and Regulatory Reform Bill, will have to be amended, or whatever is done with these Bills, to make them compliant with existing law, or the existing law has to be repealed or amended. However, there has to be some congruence between the two pieces of legislation, and I think that there is a recognition that these two pieces of legislation, in their present form, do not sit easily side-by-side in every particular. However, I think that the matching of the two pieces of legislation will start happening more seriously once the Government of Wales Bill is on the statute book, and then this particular piece of legislation will have to be made compliant with that, or the Government of Wales will be adjusted to reflect some of the issues. It is fiendishly complicated, and I do not know whether Peter wants to have a go at it. However, that is my understanding.

[135] **Rhodri Glyn Thomas:** Peter, a oes rhywbeth ar yr ochr gyfreithiol y medrwch ein goleuo arno?

Rhodri Glyn Thomas: Peter, is there anything on the legal side that you can enlighten us about?

[136] **Mr Jones:** I agree that it is a difficult Bill to understand. Basically, it confers a function on a Minister of the Crown, that is, in Whitehall, to make an Order, which would be a Westminster Order—reducing burdens and so on—and can amend legislation. The relevant provisions in the Bill relating to us in Wales, are, first, clause 12, which says that any Order made by a Minister of the Crown, may not make any provision conferring a function on the Assembly, or modifying or removing the functions of the Assembly, except with the agreement of the Assembly.

11.20 a.m.

[137] So, insofar as the Assembly has a function, that cannot be removed or modified except with the agreement of the Assembly. There is also another provision, in clause 14, which says that, with regard to any other matters, such as how a function should be exercised, any Minister of the Crown has to consult the Assembly. The problem, post May 2007, is these provisions dealing with the agreement of the Assembly or consulting the Assembly, because the Assembly will be split between Welsh Ministers and the Assembly. Now, the functions of giving an agreement, or consulting, will be vested in Welsh Ministers, because of Schedule 11 to the Government of Wales Bill. The question is how should the Assembly itself get involved in giving consent or consulting. I think that something will have to be done to achieve those objectives, either by consequential provisions Orders or by amending this particular Bill, but the concern, basically, is that a Minster of the Crown could remove a function of the Assembly and, post 2007, it would only require the agreement of Welsh Ministers, and not the Assembly. That is the concern, in how the Assembly should get involved in giving consent or being consulted.

[138] **Rhodri Glyn Thomas:** Ysgrifennaf at Gadeirydd y Pwyllgor Busnes i ddweud ein bod ni wedi trafod y mater, a'n bod yn parhau i fod ymhell o fod yn glir o ran yr oblygiadau. [*Chwerthin*.]

Rhodri Glyn Thomas: I will write to the Chair of the Business Committee to say that we have discussed the matter, and that we are still far from clear on what the implications are. [*Laughter*.]

[139] **Helen Mary Jones:** It may not be appropriate for you to do this in your letter, as I do not think that we have time to build consensus on this on the day, but I would certainly want to put on record with you that any move to remove a power of the Assembly ought to be

something that the whole legislative body, after 2007, should have to agree to, so that it could not be a deal done by Ministers behind closed doors. I do not think that we would be in a position to advise on what mechanism might be sought in that regard, but it would be imperative that that does not fall to a deal that could be done between Assembly and Westminster Ministers if it involves removing a function. That ought to be a matter that the whole legislative body should have a view upon.

[140] **Mr Jones:** This is particularly so when the Assembly makes measures. If nothing were done, a Minister of the Crown could remove a function made by the Assembly through a measure without the agreement of the full Assembly. So, something would have to be done, yes.

[141] **Rhodri Glyn Thomas:** Credaf fod Helen yn gywir, ac ni fyddaf yn cynnwys hynny yn y llythyr, ond mae'n rhywbeth y dylem fod yn ymwybodol ohono.

Rhodri Glyn Thomas: I think that Helen is correct, and I will not include that in the letter, but it is something that we should be aware of.

11.23 a.m.

Adolygiad y Pwyllgor o Wasanaethau Canser
Committee Review of Cancer Services

[142] **Rhodri Glyn Thomas:** Croesawaf y grŵp ymgynghorol arbenigol a sefydlwyd gennym ar gyfer yr adolygiad o wasanaethau canser. Mae'r Dr Andy Fowell yma, sy'n feddyg arbenigol mewn meddygaeth liniarol yn Ysbyty Gwynedd. Ef yw cadeirydd y grŵp. Gydag ef y mae Anne Mills, Maureen Noonan, Sian Evans a Dr Malcolm Adams, a oedd gyda ni yn ein cyfarfod wythnos yn ôl. Croeso ichi. Cawsoch eich cyfarfod cyntaf y bore yma, felly, gofynnaf i gadeirydd y grŵp, Andrew Fowell, i wneud sylwadau agoriadol.

Rhodri Glyn Thomas: I welcome the expert reference group that we established for the review of cancer services. Dr Andy Fowell is here, and he is a specialist doctor in palliative medicine at Ysbyty Gwynedd. He is the chair of the group. He is joined by Anne Mills, Maureen Noonan, Sian Evans and Dr Malcolm Adams, who was with us at our last meeting a week ago. Welcome to you. You held your first meeting this morning, so, I invite the group's chair, Andrew Fowell, to make his opening remarks.

[143] **Dr Fowell:** Thank you very much. Unfortunately, I missed most of that, but my Welsh is just about up to understanding what you said.

[144] **Rhodri Glyn Thomas:** I was only welcoming you and handing over to you for your introductory remarks.

[145] **Dr Fowell:** Thank you. Thank you for inviting me here today, and also for inviting me to chair this expert reference group to look at cancer services. We, as a group, met this morning, despite the problems with the traffic and had a useful discussion. We all feel very enthusiastic about the role that you have set us, and we are happy with the terms of reference that you have set. We discussed various things relating to the questionnaire that you sent around, but also items that we felt that we would like to pursue. Perhaps we could discuss those as we go along—I am not quite sure how you want to take this forward. Last week, when you spoke to Dr Adams, you ran through the questionnaire, but I was not sure whether you have already covered the questionnaire fully, and that is the sort of thing that we saw ourselves working on over the summer, during the recess, when all the responses are in from around Wales. The consultation period does not finish for another two weeks.

[146] **Rhodri Glyn Thomas:** You do not need to run through the questions, as we did that

last week, but we would welcome a more general discussion as to how you see the review panning out and some of the things that you want to point out in terms of the review. To the people in the gallery, if you are having trouble hearing, you may require a headset, because, as well as giving you the translation, it amplifies the sound.

[147] **Dr Fowell:** Talking this morning, there were one or two items that we were clear and unanimous about and we feel that it is important to take them forward. We certainly see having a common IT system as being of great importance, and we would stress the need for this and identify our present system as needing development, rolling out across Wales, so that we would have universal access to that. We see that as a prime and important thing.

[148] One of the other issues that we came up with immediately was one that you have identified in the questionnaire that you sent around, namely around commissioning. I will not repeat some of the words that we used to describe it, but we feel that a lot of work could be done around commissioning to make the process smoother and more responsive to the needs of Wales. At the moment, splitting it up between all the local health boards, plus Health Commission Wales and the other partners, is very confusing. It is not a simple process, and I am sure that we can do better in that regard.

[149] Other general areas that we covered were around drugs. How do we get new drugs through? How do we cope with the expense and how do we avoid the embarrassment of people camping in the Assembly demanding drugs and so on? We need to avoid such a process.

[150] We were clear that we need to look to the future. There are issues, at present, around capacity, but we need to look to the future and how we plan for future capacity, especially around the workforce. We need to have proper workforce planning. There are bids in for extra linear accelerators, but that is just for capital. We need to, in some way, look forward and start developing the extra staff that we need to go with them.

[151] One of the things that we were clear about was that a lot of work has already happened and is going on at the moment, and there is excellence going on. A lot of work has also been put into producing strategy documents and documents around standards, and the cancer services co-ordinating group members have shown themselves to be excellent at producing these standards that they are taking that forward through their clinical groups, and we are now getting into the process where we have the Welsh standards that we must meet by 2009. I am hoping that we will not have the same process that we have now, where, suddenly, 2009 is very close to us and we panic about how to get the standards in place. We have issues around the cancer waiting-time targets, where we must meet those by December of this year; I can assure you that there is a panic going around Wales as to how we will get there. I would hate to see that process being repeated in 2009 to reach the cancer standards.

11.30 a.m.

[152] We have also debated questions that you may wish to ask when you go to France on your fact-finding mission; we could, perhaps, discuss those over lunch.

[153] **Rhodri Glyn Thomas:** Does anyone wish to add anything before I open it out to committee members?

[154] **Ms Mills:** On survivorship and rehabilitation, and the success that we currently have within those areas in terms of cancer management in Wales, we need to think about supportive care and look to linking that with chronic disease management. We have discussed different roles and new ways of working in terms of taking patients through the whole spectrum of care, looking at chronic disease management as a driver for rehabilitation in

cancer care, which was unheard of until quite recently. We are clear that we want to look at quality of life during cancer interventions, and start to think about the research drivers for rehabilitation and survivorship. The public are telling us that they want us to look at that area.

[155] **Dr Fowell:** I apologise to my colleague for missing out that very important aspect. We see that there is scope to look at the way in which patients are cared for and followed up. At the moment, there is huge duplication—someone may see a surgeon followed by a radiotherapist followed by a palliative care physician in a short period of time. That is vaguely ridiculous—they should see one person.

[156] **Lynne Neagle:** I thank Dr Fowell and his colleagues for their evidence. You referred to the cancer waiting-times targets, and that your colleagues were in a bit of a panic about how they would meet the targets by the deadline. Can you expand on that and say a bit more about what they feel the obstacles are to meeting those targets?

[157] **Dr Fowell:** I made a mistake in opening my mouth on that one. The cancer waiting-times targets are 31-day and 62-day targets, which are very difficult to meet. Part of that is because of the process of diagnosing a patient and starting treatment. The steps that need to be taken take that length of time. To try to squeeze the target down further involves looking at the whole process of the way in which a patient travels through the system. If you have a problem with capacity added to that process, it is very difficult to get a patient through the whole system in that period of time. A lot of the trusts around Wales are finding that they can fine-tune a lot of what happens around diagnosis and doing the investigations, but there is a fundamental capacity issue in many places which makes it very difficult to attain these targets.

[158] **Lynne Neagle:** Is the problem of capacity related to resources or is it to do with the commissioning process at a local level? Where do the problems with capacity arise?

[159] **Dr Fowell:** I can speak from my experience within North West Wales NHS Trust, where we have a fundamental issue about operating slots for surgeons to do colorectal operations. I know that the next free slot will be after the summer break.

[160] **Dr Adams:** In relation to your very important question, one of the problems with the new standard is the difficulty of the measurement, because it is a complicated process. That is posing great difficulties for trusts. In relation to specific things like resources with radiotherapy, we have just completed a report for the cancer services expert group, which shows that none of the cancer centres are able to deliver radiotherapy waiting times with current resources, and there are also issues relating to issues such as man-power and means of working. So, I think that this is an urgent issue. Part of it is numbers of linear accelerators, but there are also other issues around man-power. That is a key issue that we need to address.

[161] **Rhodri Glyn Thomas:** If any of the group want to join in the discussion, feel free to do so.

[162] **Helen Mary Jones:** I add my thanks to all of you; we value and appreciate your contribution. We are trying to do a huge piece of work in a relatively short space of time, and we will depend on you hugely to help us with that. We have put out the questionnaire; did you feel that there were any questions that we did not ask, or did not ask in enough detail, or issues that we did not raise that we may need to look at? The other thing that I wanted to ask you about—and you may not want to comment any more on this now—is commissioning issues. I sensed Dr Fowell beginning to say something but not quite finishing it. I do not know whether you feel that you want to say more now or come back to us in the autumn, when you have had a chance to analyse some of the responses. That certainly seems to be a big question.

[163] Finally, Dr Fowell, you mentioned in your remarks that a lot of work has gone into producing strategies and standards. I then understood you to have said that we need to plan properly to meet them. Are you implying that there is an imbalance there and that we should, perhaps, have fewer strategies and fewer standards and more time put into implementing those that exist? Am I putting words into your mouth or reading between the lines?

[164] **Dr Fowell:** I will take those backwards and start with the implementation of strategies. There are documents around, and I was involved in helping to write the palliative care strategy for Wales, which was published three years ago. That was a big piece of work which everyone felt enthusiastic about, and we felt that this defined the way forward. The problem when you produce a document is what happens to it afterwards? If it is not linked in with the standards, then it probably will not go very far forward. The CSCG has completed the cancer standards, which have been published—they are out there and we have to meet them by 2009. We now have action plans to get there. However, those action plans require investment. We are not so unrealistic that we do not realise that that is not what is happening at the moment. The LHBs and the trusts are not in a position to say to us, 'Where does the money need to be spent?'. It is the other way around; the question is 'Where can we save money?'. So, I think that frustration would be the correct word to use. In the present climate, it is rather difficult to see how we will meet these standards by 2009. Within my own field of palliative care, the CSCG commissioned a major piece of work on a needs assessment, which was carried out by Peter Tebbit from the National Council for Palliative Care. It has been recognised as an excellent piece of work. It identifies where the gaps are. However, I am not sure how we will fill those gaps.

11.40 a.m.

[165] Commissioning is a difficult one. We see the present state of affairs of having to deal with numerous LHBs as time-consuming and frustrating, but we can fully understand that the LHBs have a statutory responsibility to commission services, and they need to know that they are doing the right thing. We have seen movements whereby there has been agreement with LHBs that one will start to be the lead commissioner for certain services, but that is developing very slowly. Again, I have to use examples from my own knowledge. In north Wales, one LHB has agreed to be the lead commissioner for oncology, but it is only allowed to vary from the agreed budget by £60,000. So, there is not much scope to move one way or the other. One could understand why people are not willing to let go of their budgets, but, at present, it is frustrating.

[166] In terms of areas missed, I will turn to my colleagues. What else did we talk about that we felt had been missed? We have mentioned chronic disease management, psychology, rehabilitation, and how we deal with long-term survivors. We talked about linkage and partnerships. It is very difficult to take cancer in isolation. If you look at urology services, you will see that there are long waiting lists for operations that are not cancer related. If you increase capacity in urology as a whole, you start to deal with the cancer patients more quickly. So, we need to develop the links. One of my colleagues mentioned some of the drugs. Herceptin, the new drug for breast cancer, requires the patient to have echocardiograms. We now need to go to the cardiac networks to discuss what their requirements are for increased capacity in doing those. We need to develop these linkages across.

[167] **Ms Evans:** To follow on from your point about Herceptin in particular, the questions on drugs were very specific. I think that there are more general problems, particularly with the managed entry of new drugs and the associated workforce and capacity issues. NICE recommends a drug and the funding for the drug follows, but it is often very difficult to have the capacity and the workforce to follow it. There is a lot of duplication of effort in forward planning and horizon scanning for new drugs, which everyone seems to be doing in isolation.

[168] **Dr Adams:** I think that the other thing is about how quickly things move. Herceptin is currently a key drug. The American Society of Clinical Oncology is already looking at a successor this year, which will be an oral preparation; it is going into clinical trial and it may replace Herceptin within five years. So, you need a tremendous amount of horizon gazing in order to plan.

[169] On commissioning, what may be important is appropriate commissioning. If one is talking about radiotherapy, in my view, regional commissioning would be appropriate. The other thing that one has to consider is that, if you are talking about very expensive equipment, such as linear accelerators, it is important that Wales gets best value from the companies and that the contracts are negotiated on an all-Wales basis.

[170] **Rhodri Glyn Thomas:** Do you want to come in, Jonathan?

[171] **Jonathan Morgan:** I will also start by thanking the group. We know that these committee reviews are never easy processes for us to be involved in, but, very often, we do rely on expert advice. I am certainly very grateful for the work that you have done so far, and we look forward to a very productive working relationship right up until we produce the report, and, hopefully, beyond that.

[172] I have a couple of points to raise. Andrew mentioned the issue of future capacity and how we tackle that in terms of planning. Looking at the present arrangements, how accurate can the planning of future capacity be? What are the sorts of pitfalls or particular challenges that clinicians and managers face in trying to predict and/or plan future capacity?

[173] My second question is for Malcolm. You mentioned the fact that none of the radiotherapy centres are meeting their target waiting times. I know that this figure may be difficult to pluck out of the air, but, on average, how long is patient A waiting beyond the target time to receive the radiotherapy that he or she needs? Do you have a range, roughly, in your mind as to how long patients are being expected to wait beyond the target time that radiotherapists have been given?

[174] My third question is to Sian, on the drugs and how we horizon scan and provide for the new drugs that are coming on stream. Can we glean any evidence from other European Union countries? I know that they have various processes for approving drugs, but is there any best practice or examples elsewhere in the EU that we could learn from in terms of that sort of horizon scanning, which I imagine is quite a difficult task to undertake?

[175] Turning back to Andrew again, you mentioned the fact that target waiting times for this year were very difficult for clinicians to meet, and I wondered what the particular challenges were in preventing clinicians from meeting those target waiting times. Is it purely resourcing, is it a lack of certain individuals within certain specialities, or is it that we are providing services, but not necessarily in the correct geographical places in Wales? What are the particular problems?

[176] **Dr Fowell:** On future capacity and horizon scanning, it is difficult. What we know is that we have an ageing population, and that, as we get older, we are more likely to get cancer. The other thing that has happened over the past five or 10 years is that the scope of chemotherapy, especially, has expanded greatly, and we are now treating older patients who, in the past, would not have been treated. We are also treating patients who previously would not have been treated because it was thought that it was not appropriate—they are now being treated more effectively with newer drugs. I am sure that that will continue to happen in the future and that there will be an expansion. Our own practice in Bangor has increased by 40 per cent over five years, and that has put the unit that was only opened five years ago under

incredible pressure. We do not have the space to treat patients. Our waiting space is full and the treatment area is cramped and not really appropriate at the present time. I am sure that we will continue to see increased pressure upon that. It is very difficult because, at the moment, we are planning to expand, but we do not know how big we need to make it. If we invest a large sum of money in building an extension on to the existing unit, it is difficult to know whether that will be full within four or five years.

[177] On the other hand, as Malcolm said, some of the newer treatments are now being given orally rather than intravenously, and that makes a big difference to how much space we need and how many staff we need. It also makes a difference to pharmacy, in terms of preparation and whatever. Unfortunately, those newer drugs tend to be more expensive, but there is a play-off between the expense and the time and effort that must be given. Those things are happening at the moment, and it is very difficult to predict future capacity. On the other hand, with radiotherapy, we can be a bit more specific about the need for more equipment and the staff that we are going to need for that. That is more predictable. It is quite difficult to get a feel for the drugs issue and it is changing very quickly. However, one of the questions in the questionnaire was about whether Wales was up there and responding. I want to get the message across that Wales has a first-class service. However, it is tight and cramped at the moment, and, if we look to the future, it will get worse. What else did you ask me?

11.50 a.m.

[178] **Ms Mills:** I will come in on the point that you made there, Andy. The increasing use of oral medications does not mean a reduction in the toxicity associated with the oral medications. In fact, some of the drugs are even more toxic than some of the IV drugs that we currently prescribe. There is a capacity issue in administering intravenous drugs, but the patient still needs to be admitted into hospital care for the toxicity management. So, the more that we are able to give orally, the more bed usage there will be for toxicity management. We need to be mindful of that message.

[179] **Dr Fowell:** On the question of waiting times, and whether it is about resourcing or whether it is geographical, there is a lot of work going on across Wales to ensure that patients are treated in the appropriate place by experts with the right expertise, and that the clinical governance issues that go along with that are right. That is slowly happening; we are seeing a movement of the centralisation of services as we go along. The waiting times issue is separate to that, and, obviously, will be called into it.

[180] Is it a case of resourcing? Again, I would like to draw on the example that we have in north-west Wales, where the LHBs have agreed to put in funding for extra medical staff—consultants in urology and back-up staff—and to develop a new unit. That will go a long way to answering the waiting times issue. However, that money is only just coming through, and by the time that we appoint and develop the service to the extent to which we want to do so, we will have missed the December 2006 deadline. So, it is a case of resourcing, but, even if you have the resources, there are problems regarding recruitment and setting up the service to get it going. I will pass on the other questions that were asked.

[181] **Ms Evans:** Thank you for the question on horizon scanning. What is done in other parts of Europe is an interesting question, and one that I cannot answer. I suspect that no-one has got it right. The introduction of new drugs is variable throughout Europe, due, I suspect, to commercial and marketing preparations. It might be a question that those in the party going to France might want to ask their French counterparts. Within the United Kingdom, the UK Medicines Information consortium, in conjunction with the National Prescribing Centre, produces a document called 'Prescribing Outlook', which I think most of us use as our basis for horizon scanning and forward planning. The trouble is that everyone is doing the same thing throughout Wales. I am doing it in south-east Wales, one of my network colleagues will

be doing it for south-west Wales, and someone else in north Wales national public health service is also doing that. There is a lot of duplication of effort, probably using the same data.

[182] **Dr Adams:** To respond to the question on radiotherapy waiting times, I cannot give a precise answer at the moment. I suspect that treatment times are probably up to six weeks—perhaps more in different parts of Wales, which is unsatisfactory. If we want to look to horizon planning, in relation to radiotherapy, a lot of work has been done, because the problems are not unique to Wales. Work has been done in Canada, Australia and across Europe on this question. Interestingly, they have all come out with the same thing, namely that, basically, in about 10 years' time, we will need something in the order of 58,000 radiotherapy fractions per 1 million of the population. This is what scenario groups have come up with and the figures are remarkably similar.

[183] So, we can make fairly good predictions. The issues are that we need to be looking not only at increasing our number of radiotherapy machines, but also at how they are worked—that is important—and we need to ensure that they are optimally used. There are major man-power issues as well. For example, the schools are busy producing expert radiographers, but they can leave the schools and find that there are no jobs. I sat on a committee in the Department of Health where I mentioned the fact that we could lose radiographers to England, and Mike Richards said that England would be very happy to receive them. I would like these people placed in Wales. The problem is that the commissioning has to be joined up to do that, so that there are jobs for these people when they come out of the schools.

[184] **Jonathan Morgan:** I have a quick point for clarification. Malcolm, you said that the time that patients were waiting for radiotherapy was six weeks, in comparison with—what is the waiting times target?

[185] **Dr Adams:** We would expect most radical treatment to be completed within four weeks. Waiting times are sometimes greater than six weeks, but we know that, with radiotherapy waiting times, the longer they are, the worse the prognosis, and there is good clinical evidence of that. So, patients can suffer from being on the waiting list for too long. Part of the waiting time is related to issues of diagnosis; that is, by the time they are actually referred for radiotherapy, there has often been a delay, for various reasons, and then you have problems with getting the patient a slot for the radiotherapy machines, where there is insufficient capacity.

[186] **Ms Noonan:** [*Inaudible.*]—I echo everything that Malcolm has said; there is a demand capacity problem. Things are changing all the time in techniques and patient management, and we are just trying to keep up with that, as well as with the capacity and demand problems that we have.

[187] **Lorraine Barrett:** I am interested in chronic disease management and rehabilitation. As one of the panel members said—I think that it was Anne—this was unheard of a few years ago, but people with cancer can now look forward to some quality of life. Could you say something about the joined-up working that should be possible, and whether it is happening? For instance, with regard to when the patient is home and needs ongoing care, that requires the involvement of social services, housing, GPs, district nurses, pharmacists and other groups such as voluntary or charitable cancer care organisations, possibly Marie Curie and Macmillan. Can you give us an idea of how that is working, or whether something is lacking in that package that is needed? Another organisation would be the Department for Work and Pensions perhaps, if the person concerned is working, and needs to manage his or her job as well as dealing with the illness, the rehabilitation and getting on with life to whatever extent that might be.

[188] **Ms Mills:** Thank you for that question. It is more and more in the public mind for people to live with their cancer now—and to live well with it. From that point of view, I feel that we have been quite visionary in Wales in looking at developing consultant practitioner posts in cancer rehabilitation, to give leadership on the very issue that you describe and ask about. Health Professions Wales has passed three posts currently, one in each cancer network, so we are already taking that on board. There are some areas of extremely good practice whereby the cancer charities are working well with the NHS, but it is on small ad-hoc projects, and so it is very inequitable from the point of view of a patient's experience. What we are trying to drive towards is very good early unified assessments, to look at health management and potential throughout the whole experience. We are involved, certainly in south-east Wales, in a very exciting project with Marie Curie, which has fully funded a consultant practitioner in cancer rehabilitation. That will start towards the end of the year.

[189] That post will give leadership to the development of the pathways that need to focus on how folks live with their cancer, as well as looking at the expertise needed to give really good early intervention programmes. That is where it links to the research. We talked about this earlier, and a very good question was asked about the linkage of research, and the drive towards clinical trials, but what we are looking at really is research associated with really good interventions, and about effective team working that improves the lot of the population of people with cancer.

12.00 p.m.

[190] These are exciting times, because that has been taken on board; we have listened to patients, and Marie Curie Cancer Care has picked up the baton to help us to lead on that. There are some nice projects locally, but they have small numbers, and this is about taking on board some of the innovations-type methodology and looking at the spread—not keeping it within small cohorts of people, but getting it spread throughout—and maybe even building it into the standards that folk should expect to have, so X amount of quality of life during the cancer experience. I think that that is quite exciting, at the moment, so thank you for your question.

[191] **Lynne Neagle:** I have three further questions. The first is on diagnostics and on how readily you feel people are having access to diagnosis in Wales. Do you feel that there are any significant variations in waiting times for the various types of diagnosis, and do you feel that, generally, we have the level of investment right? My second question is on staffing issues more generally. We have heard about radiography and what the challenges are there, but I am conscious of the whole range of people working in the system. Is it your view that we are getting the levels of training and the commissioning right? Those are the same sorts of questions that have been answered on radiography, but I would be interested to know more about the general situation. Finally, on health inequalities, we know that certain cancers are more prevalent in the poorer parts of Wales, and I understand that evidence is emerging of differential survival rates for certain cancers, with poorer people more likely to have poorer outcomes from their treatments. Do you have any observations on whether you are seeing that in Wales, and what do you feel are the reasons for that?

[192] **Dr Fowell:** On the diagnostics question, I am sure that if you had a radiologist or a pathologist sitting here, he would tell you that investment was needed in the service, and I am sure that there are needs in that respect in a lot of places. Certainly, there are variations in staffing levels. Some places are having difficulty recruiting radiologists and pathologists and that causes problems in some areas, but not in others, so there are variations in that respect. To a certain extent, the cancer waiting times target of 31 or 32 days has focused down on that a lot, and a lot of work has been done in individual trusts on ensuring that the diagnostic process happens quickly and effectively. The targets have been a driver in trying to improve that.

[193] Staffing issues are really interesting. We did a little work in north-west Wales on providing student bursaries to speech, language and other therapists. That proved to be effective in getting people to do courses like the three-year course, and then to come to work in the area for a couple of years afterwards. There is a fear about it, but, while we can train people in Cardiff or north Wales, there is no reason why they should not go anywhere else. Certainly, there are plenty of jobs over the border for radiographers, dieticians and whoever else to go to, so we must make it attractive to stay on and work in Wales.

[194] On the health inequalities question, I admit that I am not sure of that. My colleague, Anne, will answer.

[195] **Ms Mills:** We certainly know from data from our colleagues in Scotland—and it is not much different here, but I cannot give you the postcodes—that there is a 30 per cent difference in survival rates between different postcodes for some diseases, even with the same disease, at the same stage of presentation, with the same treatment plan, the same surgeon, the same nursing team and the same radiotherapy team. You can have up to a 30 per cent change in your survival rate, depending on your postcode. Poverty is definitely a carcinogen, and there are big issues in equalities that we need to address. Our country is no different from any of the other countries looking at changes according to postcodes, but we know the areas of deprivation, and we could compare them. That is a problem.

[196] **Dr Adams:** In relation to waiting times for diagnostics, there is enormous variation. I cannot give you the figures today, but patients wait a long time for their scans. The great thing about the new standards is that they incorporate diagnosis, and it is very important that we can monitor that. That is the importance of information technology and the adequate input of data. Once we have that, we will be able to see clearly where the hold-ups are. Off the top of my head, it is difficult to say, but one can give anecdotal evidence of situations in which patients have clearly waited too long, and their cancer is more advanced as a result.

[197] On the question of inequality, this is a major issue and it is recognised worldwide. One of the problems is that people in deprived areas tend to present late, and do not use the facilities. In my area of expertise, namely gynaecological cancer, it is interesting that patients do not take up cervical screening. I still see 20-year-olds with advanced cervical cancer who do not go to screening, and the follow-up is often not appropriate, because they have not turned up. So, one of the problems in deprived areas is that patients are not compliant with the system. Therefore, we must work out how to get to them. For example, in cervical cancer, vaccination is a key issue and it may help to overcome that.

[198] On prevention, one of the problems with a deprived population is that those people smoke a lot, their diet is often very poor and we must also get to the basis of prevention. Although I work in the area of therapeutics, the future is to reduce cancer incidence by improved nutrition, less smoking, and so on. That is important, and it must start in schools.

[199] **Rhodri Glyn Thomas:** Apologies for the noise. I understand that it is the bell from the old Chamber, which is being demonstrated, for some reason, by the Presiding Officer. Hopefully, it will stop.

[200] **Ms Mills:** I will attempt to answer your question on workforce issues. There is a feeling that the shape of the workforce is not quite right to deliver in the most effective way. There is a skillset deficit at band 4 and band 7, and we are looking at the drivers that are coming to us in terms of junior doctors' hours, and new ways of working and so on. Some work is being done at assistant and general practitioner levels at band 4, but that needs to be developed further to look at how effective those roles can be, so that we can move the rest of the workforce up the skills escalator. For band 7, they need to be working effectively. There is

some evidence coming through that there are different ways of working around what should be the same skillsets. There is a lot of work being done around that area by radiographers, allied health professionals and nurses to look at the way in which we get that contribution right, especially in diagnostics, in looking at earlier referrals, who can manage upfront, and who needs to be taken on board. At the other end of the spectrum, we are looking at follow-up management, and there is much work to be done on band 4 and band 7 skillsets to change the shape of that workforce band.

[201] **Brian Gibbons:** I have an observation to make first. It is recognised that the UK is generally slower on drug approvals than other countries in Europe. That is not necessarily a bad thing, because we have protected ourselves against some of the worst epidemics of adverse drug reactions, so our evaluation process is not a completely one-way street. The question that I wanted to ask goes back to the diagnostics issue and the skillsets that are available. On the attainment of the targets, the level of attainment is far better on the one-month target compared with the two-month target. That suggests that the time from diagnosis to treatment is probably not too bad in relative terms, but that the weakness is from referral to diagnosis and that this is where the work probably needs to be done.

12.10 p.m.

[202] While I totally agree that there are equipment shortages, the crucial thing is how the patient gets to the equipment rather than merely an equipment shortage. How far do you think, in your own experience, people are involved in redesigning the clinical pathway? In other words, there is a hallowed ritual that you are referred by your GP, you see the consultant, the consultant forms an opinion and sends you off to the radiographer or to the lab, and the lab sends the results back. It all adds time to the process. What is going on to redesign the process so that, if a person is referred to a consultant, all the x-rays will be there and the various investigations have been done? There is no reason why a nurse practitioner should not see a patient between the time of referral and their being seen by a consultant and have all of the baseline investigations done so that when the consultant sees the patient, everything is there in order to make the decision, and the consultant can consequently refer a patient for treatment straight away. What is the mood out there with regard to redesigning the patient pathway? Or is it that people are too settled in their ways and achieving the culture change is just too difficult?

[203] **Dr Fowell:** Taking up that last point, I think that the targets have been a huge driver to make people look at the patient pathway and how we get someone through it. The target two or three years ago was to get the patient seen, following an urgent referral, within 10 working days. Achieving that meant big changes in the processes. I think that the new targets that we have been set for this year have again made people look closely at how you do the very things that you have talked about—how do you get them through diagnostics, how do you get the pathology results back, and how do you make sure that all of that is available at the right time? There is a lot of work being done around that at the moment. That has been driven by the targets that you have set us. I feel quite confident that people are changing their practice. We are now working on pooled referrals to surgeons. We are trying to get the surgeons to look at sharing operations between them, so that the one with a long waiting list hands them over to someone else.

[204] There is some inertia about strongly-felt things like that, but a lot has changed. We have seen multi-disciplinary team working, which can potentially add in a bit of a delay. However, we have seen a lot of redesign. You mentioned the nurse practitioners taking an active role in this process, and they have picked this up and are running with it. I think that that has been a huge step forward in the last year because of the targets. So, although we complain about the targets—and bitterly—they have made us do things and get on and get going.

[205] **Ms Mills:** There is a wholesale approach in the west Wales cancer centre looking at early diagnostic work for colorectal cancer. We know that the lists are being, in effect, skewed because of long waiting lists to see consultants, and, for the five out of the 100 who have cancer, while they are on that waiting list, the disease is progressing, and 95 out of the 100 will be the worried well who have bowel problems. We are causing a backlog in the systems and there are huge waiting lists for the endoscopy suites. I know that West Wales Cancer Centre has been involved in a new project looking at using the CADE tool for nurse practitioners and GPs to do much better assessments of bowel problems up-front. The spread of that kind of work can only get better. They are reducing the numbers of the worried well, so those with irritable bowel syndrome can be seen by generalists and managed by GPs and do not have to go onto urgent waiting lists, which is much better. So, that is a successful story. The nurse practitioners and practice nurses have taken that by the horns. The pooled referral system alongside that, and not just referrals between consultants who are friends, is certainly working much better. I think that a culture shift is happening. We need more of it and we need to spread that work. I think it is happening in pockets, where you have champions in the redesign and innovation champion work. The spread is coming forward slowly, but I certainly would like to see it being taken up quicker or more urgently.

[206] **Rhodri Glyn Thomas:** Thank you very much. You will be aware, from the comments of committee Members, that we very much appreciate your co-operation, the fact that you have agreed to sit on the expert reference group, and that you are prepared to share your knowledge, experience and expertise with us. Without that, we would not be able to undertake this review because of the timescale. We are indebted to you and look forward to working with you over the next six months.

[207] Diolch yn fawr iawn.	Thank you very much.

[208] That concludes the business of the committee.

Daeth y cyfarfod i ben am 12.16 p.m.
The meeting ended at 12.16 p.m.