Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

The National Assembly for Wales
The Health and Social Services Committee

Dydd Iau, 28 Medi 2006

Thursday, 28 September 2006

Cynnwys
Contents

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

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

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

Swyddogion yn bresennol: Ken Alexander, y Gangen Gwella Ansawdd a Diogelwch; Natalie Cooper, Arolygiaeth Safonau Gofal Cymru; Ann Lloyd, Pennaeth, Adran Iechyd a Gofal Cymdeithasol; Dr Tony Jewell, Prif Swyddog Meddygol; Denise Puckett, Uned Fusnes yr Adran Iechyd a Gwasanaethau Cymdeithasol; Richard Tebboth, Arolygiaeth Gwasanaethau Cymdeithasol Cymru.

Eraill yn bresennol: Dr Andy Fowell, Meddyg Ymgynghorol mewn Meddygaeth Liniarol, Ysbyty Gwynedd.

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

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

Officials in attendance: Ken Alexander, Quality and Safety Improvement Branch; Natalie Cooper, Care Standards Inspectorate for Wales; Ann Lloyd, Head, Health and Social Care Department; Dr Tony Jewell, Chief Medical Officer; Denise Puckett, Department for Health and Social Services Business Unit; Richard Tebboth, Social Services Inspectorate for Wales.

Others in attendance: Dr Andy Fowell, Consultant in Palliative Medicine, Ysbyty Gwynedd.

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

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

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

[1] **Rhodri Glyn Thomas:** Bore da, a chroeso i'r cyfarfod hwn o'r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol.

Rhodri Glyn Thomas: Good morning, and welcome to this meeting of the Health and Social Services Committee.

[2] Yr ydym wedi derbyn neges oddi wrth Lynne Neagle, yn ymddiheuro na all fod yn bresennol—nid yw hi'n hwylus. Deallaf fod yn rhaid i Jonathan Morgan adael am 12 p.m.. Heblaw am hynny, nid wyf wedi derbyn unrhyw ymddiheuriadau eraill.

We have received a message from Lynne Neagle, apologising that she cannot be present—she is unwell. I understand that Jonathan Morgan has to leave at 12 p.m.. Apart from that, I have not received any other apologies.

[3] Arhoswch tan fod y golau coch wedi goleuo ar y meicroffon cyn siarad—nid oes angen i chi wneud unrhyw beth. Arhoswch nes bod y golau coch yn dangos yn glir; bydd hynny'n sicrhau nad ydym yn colli dim o'r trafodaethau. Mae offer cyfieithu ar gael hefyd, sy'n ychwanegu at y sain os oes angen hynny arnoch.

Please wait until the red light appears on the microphone before you speak—you do not need to do anything. Wait until the red light shows clearly; that will ensure that we do not lose any of the proceedings. Translation equipment is also available, which amplifies the sound if you require that.

[4] Atgoffaf bawb, gan gynnwys y bobl yn yr oriel gyhoeddus—a chroeso cynnes i chi—fod angen diffodd yr holl offer technegol; nid yw'n ddigonol ei fod ar 'ddistaw'. Mae hynny'n cynnwys BlackBerrys yn ogystal â ffonau symudol.

I remind everyone, including the people in the public gallery—and a warm welcome to you—that all technical equipment must be switched off; it is not sufficient for it to be on 'silent'. That includes BlackBerrys as well as mobile phones.

[5] Os oes unrhyw achos i adael yr adeilad, dilynwch gyfarwyddiadau'r tywysyddion.

If there is cause for us to exit the building, please follow the ushers' directions.

9.32 a.m.

Adroddiad y Gweinidog
Minister's Report

[6] **Rhodri Glyn Thomas:** A oes gennych unrhyw beth i'w ychwanegu i'ch adroddiad ysgrifenedig, Weinidog?

Rhodri Glyn Thomas: Do you have anything to add to your written report, Minister?

[7] **The Minister for Health and Social Services (Brian Gibbons):** There are one or two points that may not be totally clear.

[8] You will see mentioned in the appendices the decision to allow the special protocol to be lifted from Cardiff social services. It is not clear in the text that we have taken a similar decision on Blaenau Gwent. Both organisations—Cardiff and Blaenau Gwent, but particularly Blaenau Gwent—have shown tremendous improvements since they have been working more closely with the Social Services Inspectorate for Wales, the Welsh Assembly Government, and a range of other partners, such as the Welsh Local Government Association. The progress that has been made is such that we feel that the organisations are now in a position to continue to monitor their own situation; they have developed a capacity to put in place continuing improvement. It is fair to say that no organisation is perfect, and the fact that the protocol has been lifted should not be seen as an indication that the organisations are perfect in that sense. However, the decision is that they have the capacity, and have made sufficient progress, to allow them to be able to take full control of their own affairs.

[9] It is probably worth pointing out the commissioning framework; it is an important document. Equally, we can take particular pride in the inclusion of the annual health checks for people with learning disabilities. I believe that Wales is the only part of the United Kingdom that is doing this. Again, it is an area on which we have been able to take a lead. The initiative that we have taken as part of the new general medical services contract has been warmly welcomed by Mencap. However, a recently published report by the Disability Rights Commissioner for Wales drew attention to several areas where the approach that we are taking towards people with a learning disability in Wales is very much at the leading edge. Again, the situation is not perfect by any means, and the whole purpose of the report was to highlight the inadequacies. However, in terms of performance vis-à-vis other parts of the United Kingdom, we have made pretty significant progress.

[10] **Rhodri Glyn Thomas:** A oes sylwadau ar y gwasanaethau cymdeithasol yng Nghaerdydd a Blaenau Gwent, neu ar iechyd meddwl, cyn ein bod yn symud ymlaen at yr adroddiad ysgrifenedig?

Rhodri Glyn Thomas: Are there any comments on social services in Cardiff and Blaenau Gwent, or on mental health, before we move on to the written report?

[11] **Jenny Randerson:** I strongly welcome the progress, particularly as an Assembly Member for a Cardiff constituency. I know the effort that the staff concerned have made, and the focus that the council as a whole has put on it. That is very much to be welcomed.

[12] **Rhodri Glyn Thomas:** Yr wyf yn siŵr ein bod oll yn ategu hynny, ac yn gwerthfawrogi'r cynnydd a gafwyd yng Nghaerdydd a Blaenau Gwent.

Rhodri Glyn Thomas: I am sure that we all support that, and that we appreciate the progress made in Cardiff and Blaenau Gwent.

[13] Cymerwn eitemau 1 i 5 yn yr adroddiad yn gyntaf. Fe'ch cyfeiriaf yn benodol at eitem 4 ar frachytherapi. Gofynnais i'r Gweinidog gynnwys hwn yn ei adroddiad oherwydd byddwn i gyd wedi clywed am achosion yn ein hetholaethau, a bu protest yma rhyw wythnos yn ôl, gyda phobl yn tynnu sylw at yr hyn yr oeddynt hwy yn ei weld yn anghysondeb yn y ddarpariaeth yng Nghymru a Lloegr. Yr oeddynt yn teimlo nad yw dynion sydd angen y driniaeth hon yn gallu ei chael yng Nghymru. Mae'n fater o bryder, a'r hyn sy'n ein gofidio, Weinidog, yw'r posibilrwydd bod dynion yng Nghymru yn cael eu gwrthod am y driniaeth hon am resymau ariannol yn hytrach nac am resymau clinigol. Er ein bod yn derbyn bod cyllideb y Cynulliad yn benodol, yr ydym yn gobeithio bod penderfyniadau fel hyn yn cael eu gwneud ar sail glinigol yn hytrach na sail ariannol.

We will take items 1 to 5 in the report first. I refer you specifically to item 4 on brachytherapy. I asked the Minister to include this in his report because we will all have heard of cases in our constituencies, and there was a protest here about a week ago, with people drawing attention to what they see as an inconsistency in the provision in England and Wales. They feel that men who need this treatment are not able to receive it in Wales. It is a matter of concern, and what troubles us, Minister, is the possibility that men in Wales are refused this treatment for financial reasons rather than clinical ones. Although we all accept the fact that the Assembly's budget is finite, we hope that decisions such this are taken on a clinical basis rather than a financial basis.

[14] **Helen Mary Jones:** I just wish to add to the concerns that the Chair raised, Minister, and unpick this to a certain extent. It has been put to me that one of the alternative therapies is more traditional radiotherapy treatment. Can you tell us whether that treatment is much more expensive than brachytherapy? I am concerned that this is not so much a matter of cost, as where the budget lies. Patients have told me that they have been told that their local health board can pay for radiotherapy, which they perceive as being more invasive, and not ideal for the particular prostate cancer that they have, but there is no money in Health Commission Wales to pay for the less invasive treatment. If that is so, surely there must be some possibility of moving some budgets around. We can probably accept that there may be an issue of not being able to fully commission the new unit at Velindre, although I think that that is a great pity if that is so. However, if it really is the case that money is available in one part of the national health service to give these people treatment but not in another part, and that the sums of money are not hugely different, then surely there must be some way of resolving this because, as I understand it, the timing of this can be crucial, and if somebody is not treated at the right stage, it can be too late for the less invasive treatment to be successful for them. So, is it a matter of the cost being too high, or of where the budgets lie? If it is to do with where the budgets lie, I appeal to you to do something about that. There must be some way to deal with that, because my understanding of the situation earlier in the summer was that people were being told that they could be treated at existing centres in England if the centre in Wales was not ready. If this is just a matter of Chinese walls in terms of budgets, then the situation is pretty grim, and I would appeal to you to sort it out.

[15] **Jonathan Morgan:** I have a similar concern about the detail in the paper, and the

idea that the cost difference was significant. What do you term 'significant'—how much difference was there between the costs identified and the budget that you allocated? If there is a significant difference between the budget allocated by your department and the anticipated cost, or the cost identified by the specialist centres in England, why were the figures so dreadfully wrong? Was it a matter of saying, 'Well, we haven't got enough money; therefore, this is all we can allocate, and as a result, we will try to pitch it at this level', or was there any research done initially to find out what the likely costs would be before you considered the budget? It seems a little haphazard if there are such significant cost differences.

9.40 a.m.

[16] What also concerns me is that, presumably, these specialist centres in England offer a service to patients living in England and are therefore able to get the treatment funded by the UK Government. I am little concerned that, if this service is on offer to English patients who are funded by the UK Government, citizens in Wales are effectively being treated as second class. That is of great concern, particularly with this service being on offer across the border.

[17] **Jenny Randerson:** Starting with that issue, can the Minister tell us exactly how much it costs? How much are the English centres hoping to charge us? How many patients a year from Wales are we looking at? I have been told that it is probably about 200, but I would welcome a more accurate figure than that so that we can get some kind of estimate of the impact on the budget. Did you take into account the fact that, for patients receiving brachytherapy, the outcomes are much improved and it is far less likely for there to be complications such as incontinence, which cost the NHS over the rest of a patient's lifetime?

[18] Chair, do you want me to go on to the other issues, one at a time, or shall we come back to those?

[19] **Rhodri Glyn Thomas:** No, I will come back to you on those. We will stay with brachytherapy at the moment. That is a crucial point. If that is the best possible clinical provision for the patient, then surely there should be a way of ensuring that the patient receives that treatment rather than being forced into another treatment that might not be the ideal provision in his case. Karen, do you want to come in on this?

[20] **Karen Sinclair:** In the report Brian states that:

'The difference between the anticipated cost of commissioning this service and the actual cost is significant'.

[21] So, are the specialist centres in England charging Welsh patients more than English patients? No? So, it was just a budgetary difficulty. How did we get into that difficulty then? Surely there was an indication of how much it was going to cost per patient and surely there would have been some rough idea of how many people wanted access to this provision.

[22] I have another question, and this might be totally off the wall because I do not pretend to be medical at all. If people were waiting for this treatment this year and could not get it and were in the queue at the back end of the financial year, as it were, would they be given priority for the next financial year, or is that totally impossible?

[23] **Brian Gibbons:** First, this is not my decision; it is the decision of Health Commission Wales, and I am just explaining the decision that it has made. Secondly, it is not the case that this service is universally available in England and that somehow the situation in Wales is different from that in regions in England. If anybody wanted to have a look at the *Health Service Journal* this week or last week perhaps, they would see correspondence from one of the main prostate cancer charities making the exact point that there is variation in

provision in England, which is not the case in Wales, and they would see that part of the argument in England is on where brachytherapy fits into the overall therapeutic regime. It seems implicit in the letter that some primary care trusts in England take the view that bracytherapy is not on the same par as prostatectomy, the surgical removal of the prostate, or external-beam radiotherapy. So, they take a slightly different view on the relative efficacy of the procedure. Having said that, our view is, by and large, the view of the National Institute for Health and Clinical Excellence, which says that there is not any therapeutic advantage to brachytherapy. Equally, there is no significant difference in terms of adverse effects. So, it is basically on a par with the existing treatments. It is more so in this case, because you must undertake surgery to insert the radiotherapy pellets; brachytherapy as a procedure would be more invasive than external therapy. It would be more convenient, because once the pellets are in, the job is done, and, once it is done, the disadvantage is that it is difficult to undo it, whereas you can always turn off, or stop giving, external beam radiotherapy if there are complications.

[24] So, the precise role of brachytherapy in treatment is an evolving situation. We accept that it probably has a role to play and this is the position that Health Commission Wales took. However, because brachytherapy is an emerging treatment, it was not included in Health Commission Wales's mainstream budget for this year, but it tried to find an allocation from its budget, which it hoped would meet the demand for this year. However, when it went to a contractor for the service, the cost was something in the order of three to four times more expensive than its initial estimate. Our understanding is that that re-costing was a consequence of the re-balancing of the payments by results in England, which is based on an average across the UK. Before the tariff has been set, you go to a certain provider and get a certain figure, but once the national tariff is established, depending on which person you went to, you will be above or below the tariff. The tariff with this was three to four times higher than was expected. That is why Health Commission Wales found itself in this situation. Even though it had tried to put ad hoc arrangements in place to meet the demand, the increase was above what it had anticipated because of the payment by results; the tariff meant that it could not treat everyone. It is currently in discussion with Velindre NHS Trust to see if it can factor this into its commissioning plans for next year. It is just that brachytherapy emerged fairly late in the budget cycle, but it did try to respond in an ad hoc way.

[25] On the point that Karen made, because brachytherapy is only one of two or three treatments for prostate cancer, patients will be offered the other two treatments. Clinically, the patient will not be at any disadvantage, although, as I said to Helen Mary, there may be an inconvenience element. However, I do not think that people are being deprived of a treatment, placing their health and wellbeing at a disadvantage.

[26] **Jenny Randerson:** The Minister did not answer my question. Can we have a ballpark figure for the cost of the treatment and how many patients we have?

[27] **Brian Gibbons:** Health Commission Wales tried to get £80,000 to £90,000 out of its funding stream to meet this. It hoped that that would treat 50 to 60 patients. However, those numbers have gone down by between a third and a quarter for the reason that I gave—the cost per case was higher than it expected.

[28] **Helen Mary Jones:** That is helpful to some extent, Minister, but the question that I asked—forgive me if you answered it and I did not pick up on the answer—was about the comparative cost per unit of brachytherapy and the more established treatments, and whether men are being offered the other treatments because their local health boards have money in their budgets for that, but not being offered brachytherapy because Health Commission Wales does not have money in its budget? Is the cost per unit a lot higher for brachytherapy? If so, are these men not being offered brachytherapy because of where the money lies rather than the fact that the money is not there, if you see what I mean?

9.50 a.m.

[29] **Brian Gibbons:** I agree that, in general, funding for most of the treatments for prostatic cancer would be within the budgets of local health boards—I think that that would be a fair comment—just like most of the treatments for breast cancer are within the budgets of local health boards. It is a common cancer and a fairly routine process. As time goes on, I cannot see a reason, in principle, why brachytherapy would not become part of the local health boards' commissioning responsibilities. The criteria for Health Commission Wales are that it generally covers low volume treatments that are highly specialised. I think that there is a certain level of specialist expertise in doing brachytherapy at the moment, so that might be why it is a relatively low-volume, high-expertise process that might conceivably fit within the remit of Health Commission Wales. The point that you make is that, in the long run, you do not think that that would be the best place for it to sit. In any event, when we come on to the commissioning framework, I think that some of these issues will fall out of Health Commission Wales, into the regional commissioning framework. I do not know whether the chief medical officer wants to add anything to that.

[30] **Dr Jewell:** I absolutely agree with the points that you made, Minister. Prostate cancer is a very common cancer in men—more common than breast cancer in women. It is a common cancer for which there are treatment pathways already available through the cancer networks and standards. Brachytherapy is a new form of treatment for which there were no providers in Wales, so it was commissioned outside Wales for those patients who the clinicians and the commissioners agreed fitted the criteria.

[31] As the Minister said, at the moment, the evidence is uncertain that it is of benefit, as against external radiotherapy and radical surgery, which are currently commissioned as part of the common cancer pathway. Health Commission Wales was involved because it was a novel treatment, commissioned externally, that was gradually being introduced. If the evidence shows that brachytherapy has a significant and continuing role in the management of prostate cancer, we would be looking for a local provider and it would be part of the normal common pathway for what is a common cancer. We are observing a transition, depending on what the evidence shows in the end. Once it becomes part of an established treatment for prostate cancer, I would see it coming into a local provider as part of the normal cancer services provision. I think that we are in a transition phase on this. On the point about cost, if you meant the cost of radical prostatectomy surgery plus radiotherapy, the costs would not be hugely different.

[32] **Helen Mary Jones:** That is what I was trying to pick out. So, it is just a question of where the budget sits.

[33] **Dr Jewell:** No, it is also a question of whether it works and whether it is preferable.

[34] **Rhodri Glyn Thomas:** Symudwn ymlaen yn awr. Yr ydym wedi cael trafodaeth weddol eang ar hwn ac fe awn yn ôl at eitemau 1, 2, 3 a 5 yn awr.

Rhodri Glyn Thomas: We will now move on. We have had quite a wide ranging discussion on that and we will now go back to items 1, 2, 3 and 5.

[35] **Jonathan Morgan:** First, I will deal with point 2, the commissioning framework. On this, I was quite curious about what is not being done at the moment. What is the problem with the present commissioning arrangements, particularly with the 22 LHBs, that needs to be altered within the new commissioning framework? We have to remind ourselves that it was your Government that decided to localise commissioning responsibility, particularly for primary care. It was a huge principle that was set out by the Assembly Government, that 22 LHBs were necessary, with coterminousity with 22 local authorities. My party, at the time,

took a different view, and still takes a different view. How does this all fit in with that principle of local determination? What will this mean, in a practical sense, for the ability of local health boards and trusts to make decisions according to the needs of their local community?

[36] You say, in the document, that there will be regional commissioning units in each health region and that the staff would be sourced from existing staff, but what are they currently doing? Do they work within the field of commissioning or are these people being taken from various other departments? What are their backgrounds and is this is the most suitable way of proceeding? What would be the level of bureaucratic interference? If this is being driven by the three regions, how is it being done—is it being driven at an official level? Where does the responsibility lie? Is it about the regions deciding what they need and saying to the LHBs and trusts, 'This is what you now have to deliver', or is it informed by the needs of the local communities, either within LHBs or within trust areas? I am concerned by this; I am not comfortable with it, but I can see what you are trying to achieve. We must accept that the starting point is that you are not satisfied with the 22 local health boards; I suspect that you are trying to put Humpty Dumpty back together again after he has fallen off a wall.

[37] **Jenny Randerson:** Are you now, in effect, taking all the commissioning for secondary and tertiary care from LHBs and saying to them that, for commissioning purposes, their staff will only be able to work together as regional bodies? I am aware that some LHBs are currently co-ordinating with neighbouring LHBs on secondary commissioning—in fact, many of them are—and all sorts of little groups have sprung up across Wales. How will this regional commissioning sit with that?

[38] I was also interested to see that tertiary care was included, because how does this sit vis-à-vis Health Commission Wales? What will the demarcation line be? Finally, why will it not be fully established until April 2009? After all, the LHBs were established well within a year of the decision. Why is it going to take three years simply to get to the point where people who are already doing the job work together?

[39] **Helen Mary Jones:** I echo some of the concerns that have already been raised. The paper specifically says that the commissioning framework is not about organisational change, but it looks like organisational change, it walks like organisational change, and, presumably, if it is going to improve, it will operate like organisational change. Two things worry me. This may well be the right way to proceed—let us see—but I worry that this will mean more meetings, more partnerships, more people sitting around in rooms, more bureaucratic cost, but still ineffective delivery.

[40] The other thing is that, whatever the faults of the local health boards, and they are many, at least people know where they are and who they are. I am not saying that I think that there is effective accountability from local health boards, because I do not, but there is an honest attempt at effective accountability. I am worried that this commissioning framework, which is allegedly not about organisational change, if put into the mix, will worsen what is already a pretty labyrinthine position for patients. We have just been discussing brachytherapy and how I can get my treatment if it is traditional treatment and the local health board is paying for it, but I cannot have it if it is a non-traditional treatment and Health Commission Wales is paying for it. If you throw the regional commissioning body into the mix, how will you ensure that the decision making on those basic issues is not even more complex, untransparent and unaccountable than it is at the moment? That is not to say that I do not think that this is the right way to proceed, because it may well be, but I am just worried that what is already a pretty opaque and complex system when looked at from a patient's point of view will potentially become more opaque and complex, with your local health board saying, 'We might like to do that, but the regional commissioning decision has been something different'.

[41] **Brian Gibbons:** The LHBs are our policy, but local government reorganisation was your policy—

[42] **Jonathan Morgan:** You cannot blame someone else.

[43] **Brian Gibbons:** Some of the difficulties that arose from coterminousity—which I think was the right decision—arose from the slightly botched local government reorganisation undertaken by your party. However, we will pass over that— [*Interruption*.]

[44] **Rhodri Glyn Thomas:** Byddwch yn dawel. Weinidog? **Rhodri Glyn Thomas:** Be quiet. Minister?

10.00 a.m.

[45] **Brian Gibbons:** First of all, these regional commissioning units need to be seen, in effect, as the agencies of the local health boards, so that the local health boards are still statutorily responsible for commissioning. However, in order to commission more effectively, in terms of improving the professionalism of the people who are currently doing it in local health boards, by bringing them together to develop their expertise so that they can be better trained and can pool their own experience and knowledge, we feel that the contracting end of the commissioning process will be much sharper and more effective. I also think that there are very few local health boards that are completely coterminous with their trust provider. Although I cannot remember who said it, I think that we have already stated that many local health boards are working in co-operation to deal with the particular fact that there is no symmetry between the trusts and the commissioning process. This is probably not outlined in this paper, but we would expect that, by and large, the relationship between the regional commissioning units would be for secondary and tertiary care, with 10 health communities across Wales. That is where the vast majority of work would be going on. So, in that sense, we would be pooling the commissioning expertise of the local health boards by setting up an agency to allow delivery to take place more effectively and efficiently and to allow the expertise to be better concentrated.

[46] I also think that, in the light of experience, there are a fair number of common conditions—it is just an arbitrary figure that I use in my own head—that have a prevalence in the community of, say, 3 per cent or lower. These are possibly conditions such as epilepsies and so forth, which are fairly common, but not common enough to really strongly assert themselves in local commissioning planning. It has proven difficult, in practice, to ensure that the services for conditions that are relatively common but are of relatively low prevalence, compared to conditions such as heart disease or respiratory disease, are available—they tend to find it difficult to get their voices heard. I think that all of us here in the Assembly meet such groups every week of the year.

[47] So, I think that these new arrangements will also provide resilience in the commissioning process for those organisations. Helen Mary, I think, or perhaps Jenny, referred to the demarcation in terms of Health Commission Wales. One of the advantages of this process is that it will allow a fair number of procedures that are currently being commissioned by Health Commission Wales at an all-Wales level to be devolved back at least to a regional level. I would not quite agree with Helen Mary in the sense that, if we can devolve these back to a regional setting, and if the regional commissioning unit is the agency for the local health boards, it will make things simpler because more commissioning activity will be returned to local health boards. They will be working through the regional commissioning unit, but, currently, there are three or four pages of stuff—some of which seems to be quite arbitrary—that Health Commission Wales does. If you go to your local health board, there is no way that you can get a handle on it. That Health Commission Wales

bag of responsibilities will become considerably smaller as time goes on.

[48] In terms of timing, I agree that three years is a long time. I think that part of that will be driven by the new health, social care and wellbeing strategies, which will be reviewed. I do not think that there is any line in the sand and that this has to be three years. I think that this is already out for consultation, and once we get the feedback on it, the process will start fairly quickly. If it is possible to progress more quickly, we will be happy to do that. I did not want, at this stage, to put a line in the sand that would result in people rushing ahead and then finding that they have to reverse or that deadlines will be missed. However, if we can do it earlier, so much the better.

[49] **Karen Sinclair:** What work has been done to look at the role of cross-border commissioning, particularly in north Wales and west England? Will there be a mechanism to review the effectiveness of the new commissioning body once it is established? How will it be reviewed?

[50] **Brian Gibbons:** The Assembly Government will be looking at how it is working. I am sure that the Wales Audit Office will look at it in due course, and I would also expect Healthcare Inspectorate Wales to look at the new commissioning arrangements. As you know, Healthcare Inspectorate Wales already looks at local health boards in terms of their commissioning activity and their other activities. So, I would expect that Healthcare Inspectorate Wales and the Wales Audit Office, as well as our own general performance management process, will look at this. Our regional offices will continue to exist and, even though this is regional commissioning, the regional commissioning unit is not part of our performance management or regional office structure, but is part of the regional structure for the local health boards. So, our performance management will continue to operate in relation to how the commissioning unit will operate.

[51] **Karen Sinclair:** Will there be a clear expectation that Health Inspectorate Wales will also get involved in this?

[52] **Brian Gibbons:** Yes, and the Assembly Government—and I think that this is said in the paper—will try to create a three-year commissioning framework from which the broad national priorities will be established. They will be updated on an annual basis, and this will be, if you like, the broad strategic steer that we will be giving local health boards to move their commissioning priorities forward. We could say that in one or two years' time we expect brachytherapy, for example, to be something that we think should be progressed. As part of the three-year programme, we might have outlined a process for how we contract services. That would feed down into the local commissioning set-up, and then the regional commissioning units would have to try to implement that at a local level.

[53] In relation to cross-border commissioning, I do not know whether there is much joint commissioning in the sense of formal arrangements for sitting down with primary care trusts, but a lot of informal discussions are taking place. There are also a lot of formal discussions between the commissioners in Wales and the English providers. Discussions would be going on in Wales, for example, between Flintshire Local Health Board and the Countess of Chester Hospital, and Powys Local Health Board would be dealing with Gobowen Hospital on a fairly regular basis. So, that will not change. Unless Ann can clarify this, I do not think that there are many joint-commissioning bodies sitting across the border doing things in the way that Neath Port Talbot and perhaps Swansea do it, in relation to the hospitals in Swansea. I am not sure that that takes place very often.

[54] **Ms Lloyd:** The new primary care trusts in England are being established now, together with our regional commissioning units. We will encourage them to have a much more active partnership in negotiating with providers in the future. Those PCTs in England

will be larger. In the past, we had to go to specialist health authorities for any arbitration or discussion on the range and quality of the services provided by English providers, but we now anticipate that, given the changing structures in England, the PCTs and the regional commissioners, on behalf of the local health boards, will join together for those discussions.

10.10 a.m.

[55] **Brian Gibbons:** There are also discussions between the Assembly Government and the Department of Health, and many of the local difficulties are at the Department of Health and Welsh Assembly Government levels rather than at the local PCT and LHB levels.

[56] **Jonathan Morgan:** I have listened carefully to what the Minister has said and he has used terms such as 'effective' and 'sharper commissioning' and so on. However, Minister, why do you not have the courage to say that the 22 LHBs, with their commissioning role, have not worked as you had thought and that that is why you are introducing a regional tier to the commissioning responsibilities of local health boards? There is nothing wrong in admitting that it has not worked as well as you had anticipated, which is why you are introducing this change. It is not as though LHBs do not work well together at the moment, as Jenny has just pointed out; there are many examples of LHBs working together. You have not outlined the problem with the current arrangement that needs curing. A little courage on your part would not be a problem from this side of the table.

[57] **Jenny Randerson:** I am struggling with this, Minister. There is an attraction to the concept and it could well be the way ahead, but I am struggling with the details of how it would work in practice. Are you talking about physically moving certain commissioners from LHBs so that they all sit together and make their decisions in one place, or will they just communicate via e-mail or whatever and meet occasionally? Will the LHBs be asked to cede part of their budget to this regional commissioning body with a blank cheque, more or less, for secondary care? If not, is it not possible that the regional body might say, 'Your LHB should commission so many hip operations this year', only for the LHB to say, 'No, we will not give you that money'? That is the current problem from the trust's point of view—occasionally the LHB will withdraw the commissioning of a particular service, which makes the service unviable from the trust's point of view. I am struggling with how it would work in detail, although, in practice, it sounds like a good step forward.

[58] **Brian Gibbons:** I disagree with Jonathan's point. The fact that we are doing this is an acknowledgement that, for secondary and some tertiary care, the commissioning process can improve. However, you have not picked up on the point that local health boards will continue to commission community care services and to work with the contractor professions and social care providers. So, the LHBs continue to do a tremendous amount of work and commissioning. The whole point of setting up the LHBs in the way that we did was to facilitate that joint responsibility for a shared population across the range of health and social care problems that people face, and to develop a commissioning framework and co-operation at a local level to ensure that services are delivered coherently for a shared population. That will not change and that is the great strength of the local health board. Anyone who wants to jettison that will do so at their peril.

[59] Where those relationships do not work well—and there have been examples in Wales of where those partnerships are not working well at an LHB level—the adverse consequences for patients and for how the overall health and social care community operates are evident. If people wish to eliminate the LHB structure, then that is their decision, but Scotland, for example, is effectively trying to invent the equivalent of LHBs, and, in England, the latest reorganisation is designed to achieve some coterminosity between social services and the health organisations. We made that strategic decision in Wales around four years ago and our decision has been vindicated.

[60] The fact that other jurisdictions in the United Kingdom are following us down that road is vindication for that. However, we can certainly do better on secondary care commissioning. In some ways, you are right that it is formalising in a more effective way what is already going on. There is a lot of bilateral and trilateral co-operation between local health boards. There are only around 10 health communities in Wales, and the local health boards are already working with those 10 health communities in that way. In many of the bigger trusts, there are lead local health boards in certain areas of activity, and that local health board takes on the responsibility for the commissioning for other organisations. So, this is putting it on a more robust and consistent basis, I would anticipate, although the full details have not been worked out.

[61] A number of issues still partially contribute to the reason why the 2009 target was given. The governance structure needs to be put in place to underpin this commissioning process. I do not think, at this stage, that a satisfactory governance structure has been put in place to underpin this. So, those things need to be put in place before we can say that this is fully fit for purpose. However, this is the direction in which we want to travel. I imagine that there will be a combination of a certain number of central people sitting in one office. There will be a small core of people there with specialist expertise, but they will be supported by the local health boards and, possibly, by people back in their local health boards who will be doing the first element of the commissioning, which is the needs assessment and so on. That will probably still require a local presence. We think that we may need to improve the contracting element. There may be a smaller number of people doing the contracting within a central unit or maybe interfacing in a slightly different way with the 10 health communities in Wales, which will be the key partners in doing this. This is out for consultation to the NHS, and some of the particular details that you are asking for will emerge from those consultations.

[62] **Jenny Randerson:** What about the last question on the budget?

[63] **Brian Gibbons:** The mechanism will be that local health boards will get the money, as always. That is certainly the thinking at the moment. However, as part of the commissioning of services, the local health boards cannot say, ‘We want 100 hip operations and here is £100 to do them’. They will have to put their money through to the commissioning units to allow them to commission the service. So, the statutory responsibility will remain with the local health board, but part of this process will involve the commissioning units having the resource to be able to commission effectively.

[64] **Rhodri Glyn Thomas:** Symudwn ymlaen at bwyntiau 6 i 9. Hoffwn gyfeirio at eitem 8, sef sut y gall y cyhoedd gael gafael ar diffibriliwr. Cefais gyfle i fynd i’r ardd fotaneg yn Llanarthne rai wythnosau yn ôl, ac mae’r staff yno wedi’u cymhwyso i ddefnyddio’r rhain. Awgrymaf yr hoffem weld hynny’n digwydd mewn mannau cyhoeddus fel hyn.

Rhodri Glyn Thomas: We will move on to points 6 to 9. I would like to refer to point 8, namely how the public can get hold of a defibrillator. Some weeks ago, I had the opportunity to go to the botanic garden in Llanarthne, and the staff there have all been trained to use them. I would suggest that we would all like to see that happening in public places such as this.

[65] **Helen Mary Jones:** I have two questions on points 7 and 9, which the Minister may be able to take together. On point 9, I assume that it is a typing error where it says,

‘initiative to deliver health checks for adults with severe learning’.

[66] I think that that should read ‘learning disability’. I want to be clear that we are not talking here about trying to differentiate between people who have severe learning disabilities

and those who have less severe learning disabilities. I was pretty sure that it was a typing mistake, but I wanted to clear that up.

10.20 a.m.

[67] The other point is on point 7, the future of the learning disability service principles and service responses grant scheme. This is always a difficult one, and you know that we have supported the principle of trying to avoid too much hypothecation. However, history also suggests that, once money that has been allocated by central Government for learning disability is unhypothecated, it gets out of the budgets of services for learning disability pretty quickly. We know what happened going back to the 1980s. I suppose that it is true to say that these services for these groups of people are not high up on the agenda of most local authorities. At one level, I am glad that the resource will continue, and I am grateful to you for that. However, I am profoundly concerned that, once this has gone into the general revenue support grant, those services that it has funded will begin to wither on the vine again.

[68] You say that the WLGA has endorsed the approach—surprise, surprise. It will obviously be pleased to be given money and not told what to do with it. However, have the organisations representing people with learning disabilities been quite so pleased? Have you discussed that with them? I ask you to reconsider this decision, but if you are unable to do so at this stage, if it is a settled decision with no way of changing your mind, can you at least tell us how you will monitor whether that money is still being spent as intended? I know that that might, theoretically, be hypothecation by another name, but so much good work has been done with this money that it would be sad to see people with learning disabilities losing that again, having had their expectations raised, and having had services put in place, particularly the stuff around independent living, which is so important for younger people. I know that that would not be your wish, Minister, but, if you will not continue with hypothecation, how will you ensure that it is not lost?

[69] **Jonathan Morgan:** On number 7, I echo Helen Mary's point, particularly with reference to the fact that this grant has been used to increase the number of respite care weeks available. If local authorities can find some easy ways of shifting money around, this may be one of those areas that is an easy picking perhaps for a local authority that needs to find money for something else. If there has been an increase in the number of respite care weeks, I would not want to see that lost, as that is an essential part of that provision in those local authority areas. If that takes a hit, there will be a great deal of concern from members of this committee and from Assembly Members generally. So, how can we keep an eye on this, and how can the monitoring keep a check on how this money is being used—just to ensure that this vulnerable group of people gets the services that it needs?

[70] **Jenny Randerson:** I also wish to underline that last point. The number of respite care weeks available is the biggest issue raised with me, generally, by carers. It is important that you ensure that that initiative continues.

[71] On point 5, the copying of letters to patients' initiatives, this is to be welcomed strongly. It is common practice in many parts of England, if not throughout England, and it has tremendous advantages. It is an issue of trusting the patient—the expert patient, and so on. On the health circular issued to trusts and LHBs requiring them to develop 'local Copying Letters implementation policies', what guidelines did you give them on how routine it should be that you copy letters to patients? I would like to see a situation in which it would be tremendously exceptional not to copy a letter to a patient, rather than sending a copy being something special.

[72] **Karen Sinclair:** I have a few questions on points 7 and 9. On point 7, I could not agree more with Helen Mary. Unfortunately, these prioritised grants often disappear once

they go into the revenue support grant. This body of people do not have a particularly loud voice, they are not sexy in the eyes of the electorate, and they have real problems. If this has to go into the RSG, how do we monitor that authorities are continuously fulfilling their obligations? That is the crux of it. We really have to look at their outputs, and I have grave concerns about this, for reasons that other people have also articulated.

[73] On the annual health checks for people with learning disabilities—and of course you might say 'I do not know' to this question—how many people with learning disabilities are there who are not known to social services? People with learning disabilities come into contact with social services only when there is a crisis in their family. So, they are out there, we have the obligation to provide the annual health checks, but how do we monitor that they are there? GPs know that they are there, but social services do not, necessarily. What attempts have been made to contact people to let them know that these checks exist, as well as those whom we already know about? When we talk about people who are 'known to social services', that is not necessarily who they are known to.

[74] **Brian Gibbons:** It is a bit of the old Donald Rumsfeld, is it not? There are some unknowns that we know, and some unknowns that we do not know.

[75] **Karen Sinclair:** However, there are some routes by which we can get information that we are not exploring. That is my point.

[76] **Brian Gibbons:** One of the big difficulties with this scheme—and there was a bit of a delay in getting it off the ground—was in agreeing where the central database to run the scheme would rest. There were fairly difficult personal data protection issues to overcome, including issues of medical confidentiality. It was quite complex trying to find a way forward. In the end, it was felt that the base from which people would start would be the people who were registered with their local authority—there is no other statutory 'register', if I may use that phrase. You have great faith in your GPs if you think that they know of all the people with significant learning disabilities; I do not think that that is the case. There was a lot of discussion on this, trying to define the number of people who would come under this scheme, and, as I indicated, it almost ran into the sand on that very issue. However, to get the scheme up and running, it was felt that that was probably the best base from which to start. It may not be perfect for the reasons that you gave, and this is not necessarily the last word on this. If there are true representations from Assembly Members or the voluntary sector, or even individuals, that the system can be improved, we would not be averse to tweaking or revisiting the system. It would, obviously, have to form part of a negotiation with the General Practitioners' Committee Wales, because this is part of the GP contract. Having said that, however, the key thing was to get started, get up and running. Mencap, and anyone who has looked at this, has been extremely positive about the fact that we have taken a lead and we have not allowed red tape to stop us from moving ahead. We really did want to deliver on this. If we can make it better by identifying the target population, there is certainly no problem in principle with working on doing that better.

[77] **Karen Sinclair:** You mentioned my 'great faith' in GPs; my argument was that it is you who is showing great faith in social services' lists. Actually, I do not think that either will come up with the goods. For instance, as people leave school and move to adult services, schools could feed information to social services. There are all sorts of ways in which it could be polished up so that it starts to make sure that it is really seeking people out rather than just getting the people who turn up.

10.30 a.m.

[78] **Brian Gibbons:** We want it to work and we want it to be a flagship scheme for Wales. Even with the work that we have done, the Department of Health has already

approached us in Wales to see how we are running this scheme and whether it could consider a similar scheme in England. As I said, in his report, the Disability Rights Commissioner was very positive about this development, and I am sure that other jurisdictions in the United Kingdom, once they have seen what we have done on this, will also want to do it. It is a start; nothing is perfect, and it is not to say that this cannot be improved upon but I prefer to take the first step and get the scheme up and running rather than to march time and say that we do not have every i dotted and t crossed and that, until we do that, we will not move forward.

[79] **Rhodri Glyn Thomas:** Ac ar y pwynt a gododd Jenny Randerson?

Rhodri Glyn Thomas: And on Jenny Randerson's point?

[80] **Brian Gibbons:** Yes, this is the eternal dilemma when you lift the hypothecation on any of these grants. The problems that you have highlighted are exactly the same considerations that occurred to me. How can we be assured? Hypothecation has been lifted in some instances and, in a few fairly important strategic areas, some local authorities do not seem to be playing the game in terms of maintaining those services. In a few local authorities, we are going to have to make decisions, certainly in relation to a number of key strategic services that had a hypothecated funding stream, and the local authorities decided not to continue with those schemes, so it may be necessary to challenge some local authorities on the spirit in which hypothecation was removed. If you look at the work that the social services inspectorate does, you will see that services for people with learning difficulties and people with physical disabilities is one of the target areas, along with children's and adult services. It is a particular area of inspection for the Social Services Inspectorate for Wales and one would hope that the SSIW, in its routine work of doing inspections, once this hypothecation is lifted, would be conscious of the fact that this has been passed over to local authorities. Richard might be able to provide some reassurance—or not, as the case may be.

[81] **Mr Tebboth:** I will try to do so. Obviously, we cannot monitor everything all the time. As the Minister has said, when we review services, we will get bits into various areas that will enable us to see some of these things. The performance indicators that are collected tell us some of the key things, the processes, assessments and reviews and so on, for each service area group, including learning disabilities. One thing that I am not quite sure about is whether the figures that we collect for the respite care provided are broken down into service groups, but I will certainly look at that.

[82] The other forms of intelligence that we have come through the professional service networks, such as networks of managers for learning disabilities services. Our inspectors attend some of those meetings, so we get to hear about it if there are concerns about services deteriorating, and things are brought to our attention in individual ways. From time to time, we and the Care Standards Inspectorate for Wales and Healthcare Inspectorate Wales look together at themes. We are currently doing an exercise on learning disability, following the events in Cornwall that caused concern. Obviously, that will not look at what is happening with this in the future, but it is an example of the way in which we sometimes look at specific areas.

[83] **Rhodri Glyn Thomas:** Ac ar y pwynt a gododd Jenny Randerson ynglŷn â chopïau o lythyrau i gleifion—pwynt 5?

Rhodri Glyn Thomas: And on the point raised by Jenny Randerson about copies of letters to patients—point 5?

[84] **Brian Gibbons:** The expectation is that all letters will be copied to patients; the default position will be that the patients should get copies of letters. There were a couple of pilot schemes before we came to where we are now, and one of the reasons that this may seem to be more advanced in England is because many of the pilot schemes were done in England, but we had three or four pilot schemes in Wales in some specialities. The two options were basically to copy everything or to provide a copy in response to a request from

the patient. Ultimately, the feeling was that copying everything would be the best approach.

[85] **Rhodri Glyn Thomas:** Yr wyf yn awr yn barod i dderbyn sylwadau ar yr eitemau sy'n weddill, o eitem 10 hyd at y diwedd. O ran pwynt 11, byddwn yn dymuno cael sicrwydd, Weinidog, bod Air Products bellach yn gallu cyflawni'r holl asesiadau ac yn gallu sicrhau fod pobl sydd angen ocsigen yn ei dderbyn. Byddai'n dda pe byddech yn gallu rhoi'r sicrwydd hwnnw inni. Fe gymerwn y pwyntiau i gyd.

Rhodri Glyn Thomas: I am now to ready accept comments on the remaining items from item 10 onwards. In terms of point 11, I would like an assurance, Minister, that Air Products can now complete all of the assessments and can ensure that those who require oxygen receive it. It would be good if you could give us that assurance. We will take all the points.

[86] **Jenny Randerson:** On oxygen, there is no mention of the secondary respiratory assessments and progress with those. When we talked about this during the crisis, you talked about how good the system was in Blaenau Gwent. I have been to Nevill Hall Hospital and talked to Dr Sue Wales about it. It seemed to me that she was on her own and that no-one else is doing the same thing. I can see why the system should be better, but if we are not doing it the system will not be better. We have only dealt with the crisis of the supply of the oxygen, and not with whether people need the oxygen of the type with which they are being supplied. So, I would be grateful if you could update us on progress with that.

[87] Item 10 refers to investment in new general medical services premises. Is there a similar scheme for investment in old premises, because many GPs do not want to move to entirely new premises but to enlarge and update existing premises?

[88] **Helen Mary Jones:** I support what Jenny Randerson said about the oxygen contract and the assessments, and I look forward to hearing your answers on that. The other question I have is about the general medical services premises. Is this money only available to traditional GP practices? For example, if you had a local health board that was experimenting with premises for salaried GPs or other models of primary care, would it be possible to access that money for the alternative models that are being tried in places where the traditional private sector GPs are not working? Is it only for GPs as such—the majority would be, obviously—or would it also be available for other types of primary care settings that might be developed?

[89] **Karen Sinclair:** On the oxygen contract, what assessment has been made of possible winter pressures? What provision has been put in place to prepare for them? I know that we are preparing for an 'if and a maybe', but it is very important to do that.

[90] On the designed to comply directive, and working towards 2009 compliance, compliance in north Wales is noted as at 17 per cent. What support mechanisms are in place to ensure that north Wales gets up to speed?

[91] **Jonathan Morgan:** On that point, given that mid Wales was at 29 per cent, north Wales at 17 per cent and south Wales at 32 per cent, has there been any further improvement over the summer? That may be slightly difficult to assess but 2009 is not that far away, and we need to ensure that we reach the target for compliance. I am not suggesting that as a member state we could be taken to court for non-compliance, but the European Union can get tough with those who do not comply. Can you give us an assurance that work is being done to help the various bodies to reach the high level of compliance that is needed?

10.40 a.m.

[92] **Brian Gibbons:** One of the penalties is that chief executives of non-compliant

organisations could end up going to jail, of course. There has not been a substantial change, because to deliver this we need systems changes rather than just individuals tweaking here and there. Indeed, in fairness, north Wales has been at the forefront of the hospital at night scheme and it has led the way on that. So, it has to be systems changes. As part of the 'Designed for Life' discussions, one of the underpinning principles is that organisations must work together, in some sort of linked way, to put in place resilient services that will allow us to have a quality healthcare system that is compliant with the 2009 requirements. I do not know whether it was Jenny who said that 2009 is not too far away, but people have asked why we are charging at reconfiguration—one of the reasons is that 2009 is not far away. If we bury our heads in the sand and say that this is all too difficult and that we want to run to the hills until after the election and so forth, time will slip by, and we may not be able to get the changes in place by 2009. The only ones who will suffer in the end will be the patients who rely on us to provide a service. So, we must have the political courage and the commitment to ensure that the system changes that are needed to underpin this are put in place across Wales.

[93] In fairness to the health service, I do not know what the situation was two or three years ago, compared to the present level of compliance, but I think that there is 90 per cent to 95 per cent plus compliance at the moment. A massive amount of work has been done over the last two to three years to get to where we are. However, that is a big challenge for everyone and we cannot bury our heads in the sand and say, 'This is too difficult and we wish that it was not happening now'. We must live up to our responsibilities.

[94] In fairness to the officials, and even the local health board people who have been dealing with oxygen, they have been a bit under the cosh in terms of delivering the oxygen contract. In pure capacity terms, I have the clear impression that they would not have been able to move forward with the assessment process until the contract was sorted out. Ideally, if the contract had come in in the way that was envisaged, we would have been much further ahead. One of my officials, Carolyn—who, as it turns out, is back from maternity leave—is leading a task group on this, and if it has not met already, it is due to meet in the next month or so, bringing the main partners together to start working on how the assessments can be rolled out across Wales. All the key partners in this, like local health boards, respiratory physicians and so forth, are involved. Hopefully, that will be the start of an implementation process, but, realistically, it just was not possible to even contemplate this until the contract had settled in. There are still discussions going on at a Department of Health level, because it is essentially a Department of Health contract, but our officials are continuing to attend everything related to this contract, and the sorts of things that are particularly related to winter pressures and so forth are also on the agenda. I do not think that there was anything else on oxygen.

[95] On premises, the overwhelming majority of GPs—it must be 95 per cent—are independent contractors, so, premises will be overwhelmingly seen within that context. I have been to a few premises that are predominantly owned by the health service where there are salaried GPs and work is going on there to make those premises fit for purpose. I do not know when it was done, but I was up at Blaenau Gwent around Easter time, and salaried doctors were working at those premises. They were traditional NHS premises, but seemed to be in pretty good nick and to have been done up relatively recently; I do not know specifically when they were done. However, it is common sense.

[96] **Helen Mary Jones:** Money would be available to—

[97] **Brian Gibbons:** Yes, it would.

[98] **Rhodri Glyn Thomas:** Wrth inni ddwyn yr adroddiad hwn i ben, yr wyf am fynd â chi yn ôl at eitem 1, lle mae'r

Rhodri Glyn Thomas: As we draw this report to a close, I would like to take you back to item 1, where the Minister explains

Gweinidog yn esbonio sut y mae'n gosod eitemau yn ei adroddiad. Mae'n gofyn yn benodol a ydych yn fodlon â'r drefn honno. Mae'n rhaid imi gyfaddef fy mod i, fel Cadeirydd, yn fodlon. A ydych yn hapus? Jenny?

how he selects items for his report. He specifically asks whether you are happy with that procedure. I have to say that, as Chair, I am happy. Are you happy? Jenny?

[99] **Jenny Randerson:** The Minister says that he would be happy to take questions on issues that are not included here. I have a few questions, if that is all right.

[100] **Brian Gibbons:** I was hoping that you might look at this in the long term. [*Laughter.*]

[101] **Jenny Randerson:** You do not have to do it now. If I give you notice of it now, perhaps you could write to me about it.

[102] **Rhodri Glyn Thomas:** Yes, perhaps we can have a note on it, because time is pressing.

[103] **Jenny Randerson:** My question is on the issue of the contaminated rice. We deal with GM contaminated rice.

[104] **Rhodri Glyn Thomas:** Bydd hynny yn adroddiad y Gweinidog y tro nesaf, ymhen mis. Bydd nodyn ar hynny yn adroddiad y Gweinidog y tro nesaf.

Rhodri Glyn Thomas: That will be in the Minister's report next time, in a month's time. There will be a note on that in the next ministerial report.

[105] **Jenny Randerson:** Okay. That is fine. The second question was simply to raise with you the issue of the stolen bones. Thank you for your written statement, which was very helpful. However, although I know that there is very little chance of contamination, your statement overlooks the fact that some of these bones were from corpses that were not of the age indicated on the death certificate. There are other concerns beyond contamination. I would like it if you could write to me and the committee specifying whether you were informed and whether you had any role in providing guidance to the trusts. You also have an inspection role in relation to BUPA, do you not? Was any guidance issued to BUPA?

[106] **Rhodri Glyn Thomas:** Os ysgrifennwch ataf, Weinidog, gwnaf yn siŵr fod y nodyn yn cael ei ddosbarthu. Karen? Yn gyflym, os gwelwch yn dda.

Rhodri Glyn Thomas: If you write to me, Minister, I will ensure that the note is distributed. Karen? Quickly, please.

[107] **Karen Sinclair:** I will also put something on the agenda for Brian to include in a report. It is about hospital car parking. This issue has been around long enough for us to really see what is going on. Anecdotally, the impact on patients and visitors is quite high. If an elderly person is in hospital, with quite a large family trying to visit them, because they like to have visitors all week, you can have quite huge bills. We seriously need to talk about this issue.

[108] **Rhodri Glyn Thomas:** Mae trefn ar gyfer hyn—os ydych am weld cynnwys unrhyw eitemau yn adroddiad y Gweinidog, cysylltwch â mi a gwnaf gais i'r Gweinidog. Byddant yn ymddangos. Credaf mai rhywbeth i'w drafod rhwng cyfarfodydd pwyllgor, yn hytrach na mewn cyfarfodydd

Rhodri Glyn Thomas: There is a procedure for this—if you wish to see any items included in the Minister's report, contact me and I will make a request to the Minister. They will appear. I think that that is something to be discussed between committee meetings, rather than in committee

pwyllgor, yw hynny.

meetings.

[109] Symudwn ymlaen.

We will move on.

10.48 a.m.

Rhestr Is-ddeddfwriaeth
Schedule of Secondary Legislation

[110] **Rhodri Glyn Thomas:** Mae'r newidiadau wedi'u huwcholeuo. Dyna'r rhai y byddem, fel arfer, yn cyfeirio atynt, ond yr wyf yn agored i gyfeiriadau eraill. Jonathan Morgan?

Rhodri Glyn Thomas: The amendments are highlighted. Those are the ones that we would usually refer to, but I am open to other references. Jonathan Morgan?

[111] **Jonathan Morgan:** I refer to page 13 of the first report. I welcome the fact that we will be looking at the regulations on banning smoking in enclosed public places. We need to ensure that we have sufficient time to examine that when it comes to the committee. I would like us to have a look at the Local Authority Adoption Services (Wales) Regulations 2006 regarding the regulatory framework for adoption services in local authorities.

[112] **Jenny Randerson:** May I just clarify, Chair, that we are allowed to refer back and ask for some clarification on earlier stuff?

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

[114] **Jenny Randerson:** On page 1, in respect of the National Health Service (Pharmaceutical Services) (Wales) Regulations 2005, is that what pharmacists call the rural regulations?

[115] **Brian Gibbons:** In part.

[116] **Jenny Randerson:** In part. What is the timetable for those? They went out for consultation last year, did they not?

[117] **Brian Gibbons:** When I was discussing oxygen with officials last week, they said that they are moving on this. The impression that I got was that, certainly, the earliest that we could expect to see anything would be Easter. I would not want to be tied down to that, but Easter would be the earliest. That is very provisional.

[118] **Jenny Randerson:** Okay.

[119] **Rhodri Glyn Thomas:** What is the delay? These were supposed to have been in place a year ago.

[120] 10.50 a.m.

[121] **Brian Gibbons:** I think that it is just their complexity. As I understand it, it is not too difficult to do one of these; but a whole complex series of regulations have built up over the years, and it is a case of trying to bring them together in a single tidy document in a way that makes sense. At the moment, it is all over the place with lots of different regulations. If it was just this one issue it probably would not be that difficult, but it is the process of consolidating the pharmaceutical regulations, which, according to what officials say, is a massive task—a sheer slog.

[122] **Jenny Randerson:** That means that it will not come to this Assembly and will be passed under a different procedure in the new system. On page 3, we see reference to original pack dispensing, which is the other lot of pharmaceutical regulations; we seem to have been waiting for this for years and there is no timetable on that either. Do you know how long that is likely to be, Minister?

[123] **Brian Gibbons:** No, I am afraid that I cannot help you on that, but we can try to get a note out.

[124] **Jenny Randerson:** On page 4, there is reference to the new oxygen contract. Why has it been delayed until April next year?

[125] **Rhodri Glyn Thomas:** Can we also have a note on that?

[126] **Jenny Randerson:** It is the National Health Service (Pharmaceutical Services) Regulations 2005, and the new oxygen contract.

[127] **Helen Mary Jones:** I have a point of information for the committee on the Sex Discrimination (Public Authorities) (Statutory Duties) Order 2006, which is on page 9. The Committee on Equality of Opportunity will be advising the Assembly to reject this Order, on the grounds that it potentially weakens the commitment of public bodies to promote equal pay.

[128] **Brian Gibbons:** Sorry, Helen, which—

[129] **Helen Mary Jones:** It is HSS 16 (06).

[130] **Rhodri Glyn Thomas:** It is at the bottom of page 9.

[131] **Helen Mary Jones:** I wanted to inform you, because it potentially has an impact on national health public bodies. It will be for the Assembly to decide whether it takes the committee's recommendation or not, but, given that it was a recommendation that was made on the advice of the Equal Opportunities Commission Wales, our committee hopes that other Assembly Members will support us. It does not affect the general duty in any way, but this Order outlines specific matters that would need to be included in the schemes. The schemes will still be needed under primary legislation, but the content of the schemes would then be prescribed by the codes of practice from the Equal Opportunities Commission and not by legislation. The reason for that is that the commitment on equal pay has been very severely watered down, against the advice of our Minister. It is an unusual step to be asking the Assembly to reject legislation, but there was a very strong feeling in committee that we should do so. I felt that I should put that on record, for this committee's information, Chair.

[132] **Rhodri Glyn Thomas:** Diolch, Helen. Symudwn ymlaen.

Rhodri Glyn Thomas: Thank you, Helen. We will now move on.

10.53 a.m.

Adroddiad Blynyddol Cynulliad Cenedlaethol Cymru ar Gydraddoldeb
National Assembly for Wales Annual Equality Report

[133] **Rhodri Glyn Thomas:** Mae pennod 6 yr adroddiad wedi ei chylchredeg gan ei bod yn ymwneud â chyfrifoldebau pob Gweinidog, gan gynnwys y Gweinidog dros

Rhodri Glyn Thomas: Chapter 6 of the report has been circulated, because it deals with the responsibility of every Minister, including the Minister for Health and Social

Iechyd a Gwasanaethau Cymdeithasol, a hefyd y prif swyddog meddygol a'r prif swyddog nyrsio.

Services, and also the chief medical officer and the chief nursing officer.

[134] Estynnaf groeso cynnes i Denise Puckett, sydd yma i'n cynorthwyo. A yw'r Gweinidog neu Denise am ddweud rhywbeth cyn i mi ofyn am gyfraniadau?

I warmly welcome Denise Puckett, who is here to assist us. Would the Minister or Denise like to say anything before I ask for contributions?

[135] **Brian Gibbons:** No, I do not have anything to add.

[136] **Rhodri Glyn Thomas:** Fe symudwn at y cyfraniadau, felly.

Rhodri Glyn Thomas: We will, therefore, move on to contributions.

[137] **Helen Mary Jones:** I very much welcome the report, because it does set out some progress. However, I do have some important comments to make; I hope that Denise does not take them too negatively. May I also say, Chair, how much I welcome the fact that this committee has put aside some time to scrutinise this, because it is something that the Committee on Equality of Opportunity has been asking other committees to do, and it has not always been easy to make time.

[138] My first comment is that the report sets out some very positive specifics, but what it does not tell us is what is being done to mainstream equality issues into the day to day decision-making of the department and, therefore, of local health boards and trusts. One is most interested in the LHBs, trusts and the GP practices—the delivery end. I am aware that a great deal of work is going on in that regard, but this report does not tell me that. You do not want to spend too long talking about process, but we all know that it is damaging for the equality agenda if it seen as a bunch of specific things done on the edge of what you do. The Government has signed up to the actions outlined in the Committee on Equality of Opportunity's mainstreaming report, so I know that you are doing things. However, it would be helpful to have those things set out along with the specifics; for example, I would like to know how staff are being trained and how we ensure that that training is pertinent to their work, rather than being of the please-be-nice-to-people-who-are-different-from-you variety. So, I am slightly critical of this from that perspective.

[139] On the examples that are used in the annexe, I may be missing something—I hope that the Chair will forgive me if I am being dense—but I am completely at a loss to see how free prescriptions relate to promoting equality of opportunity. Free prescriptions will be available to white middle-class men as much as they are to people from ethnic minorities and women. Arguably, many people from traditionally excluded groups, such as disabled people and older people, are already getting free prescriptions.

[140] **Brian Gibbons:** That is not true.

[141] **Helen Mary Jones:** It is true of people on low incomes. They are not getting free prescriptions merely because they are disabled, but many of them are on low incomes, as are women. So, I am a little puzzled about that example. However, using the expert patients programme is a very good example of how the service is practically empowering the people who use it. A little more on process might be helpful so that some of that slightly more tedious work is made visible. I have stated my view on free prescriptions—I support it and I think that it is a very good policy, but I am not sure that it is about promoting equality of opportunity.

[142] **Ms Puckett:** I welcome your comments. I have been in post since May and this report was issued last year. So, the fact that I am host project manager for mainstreaming

equality and co-ordinating what we are doing across the whole of health and social services will hopefully mean that next year's report meets all of your expectations. A great deal has been going on and I agree that, on the five departmental objectives, it is difficult to find out whether they were picked because they were equality objectives or because they were departmental objectives. That is also being addressed this year. They will be selected more according to what we are doing on equality to pinpoint areas that we are improving or that need to be improved.

[143] Much work is being undertaken on process, particularly on training. The legislation places a duty on us to ensure that our employees are trained in the equality duties and are aware of those in order to ensure that our policies and strategies are taken forward in that light. We are currently issuing training questionnaires to our staff to find out what they know and what training they have had, which will inform us and our training providers of what the department needs to ensure that we can take equality forward in a meaningful manner and not just tick boxes and so on. There has been much progress. I pushed the expert patients programme forward as soon as I got into post, because it is a positive example of how things are moving forward. I hope that future case studies will involve more of those sorts of issues so that people can see where we are going.

[144] **Rhodri Glyn Thomas:** A oes cwestiynau neu sylwadau eraill ar yr adroddiad? Gwelaf nad oes. Mae pawb yn fodlon ar gynnwys yr adroddiad ac yn awyddus i weld y gwaith yn symud yn ei flaen. Diolch, Denise, a dymuniadau gorau yn y swydd. Gobeithio y bydd y gwaith yn mynd yn ei flaen yn hwylus.

Rhodri Glyn Thomas: Are there any further questions or comments on the report? I see that there are none. Everyone is happy with the report's content and eager to see the work progressing. Thank you, Denise, and best wishes in the post. Hopefully, the work will continue well.

[145] Er ein bod ychydig o flaen amser, fe symudwn ymlaen.

We are slightly ahead of time, but we will move on.

10.59 a.m.

Is-ddeddfwriaeth—Rheoliadau Deddf Safonau Gofal 2000 a Deddf Plant 1989 (Diwygio Rheoleiddio a Chwynion) (Cymru) 2006
Secondary Legislation—The Care Standards Act 2000 and the Children Act 1989 (Regulatory Reform and Complaints) (Wales) Regulations 2006

[146] **Rhodri Glyn Thomas:** A hoffai'r Gweinidog wneud unrhyw sylwadau ar y rheoliadau?

Rhodri Glyn Thomas: Would the Minister like to make any comments on the regulations?

[147] **Brian Gibbons:** No, I do not think that there has been any further clarification or amendment. This is an important step forward. First, it puts in place the complaints procedure, which is regulated and which people can understand, particularly if you are in the private care sector. It also puts in place a system of quality assurance that will hopefully be more transparent than heretofore. One of the important principles that this sets down is that the service provider has primary responsibility for the quality assurance of the service that it delivers. Very often, the impression is that the provider does not have that duty. In the case of GM foods in shops, for example, the first person who has responsibility is the person who puts the food on the shelves, and not the Food Standards Agency or anyone else. So, it does not bring them to court. The first responsibility lies with the provider. Equally, in the care home sector, the first, and underlying, responsibility lies with the providers to have good-quality assurance in place. The first part of these regulations underpins how that will take

place.

[148] The last point that I would like to make is that the Care Standards Inspectorate for Wales wants to focus its efforts on where the problems are greatest, rather than just going to where performance is good. That is a proportionate approach. One of the things that will flow from that is that, where there are questions in relation to certain care home providers, there will be more unannounced visits, because this is something that comes up pretty regularly from service users and people who write to me—they ask why there are not more unannounced inspections. By freeing up CSIW from carrying out routine tasks and passing more over to the proprietors, time will be freed up to allow these unannounced inspections to take place where the risk is greatest.

[149] **Jenny Randerson:** I would like to ask the Minister about the comments in the response to the consultation about concerns that a move to self-assessment is a retrograde step and that organisations—and I am paraphrasing here—cannot be trusted to be accurate in their responses. In this case, we are dealing with vulnerable people. One of the issues that I recall from the situation when schools and colleges were first asked to self-assess prior to an inspection was that, with the best will in the world, they need guidance and training on how to do it. In schools and colleges, that comes about because inspectors follow in afterwards. They then say, 'You have not done this right, because of this'. So, the training is provided in that way. However, if CSIW is going to concentrate on the obvious problem areas, there will not be that training and follow-up for people doing self-assessment. It is important—although there may be a lower priority for it—that there is some kind of regular look at the reports and some kind of check against reality. Otherwise, problems can be hidden in the case of the most vulnerable people.

[150] **Karen Sinclair:** On the second-stage handling of complaints, the paper says:

'The Regulations permit providers to operate the second stage of the complaints procedure only where they are authorised to do so by the CSIW. The Regulations now make it clear that the CSIW will allow providers to run a formal consideration stage, only where this would be undertaken by someone not involved in the running of the service.'

[151] Who do you envisage that independent person to be?

[152] **Helen Mary Jones:** On access to complaints procedures, children and young people in particular often find it difficult to complain for themselves. To support these regulations, you need to have advocacy services available to enable the young person or child to know that the complaints procedure is there, and to support them through it. In the context of the regulations, what can you do to ensure consistency, and to ensure that, for example, young people in care are aware that they have the Children's Commissioner for Wales, and that, mostly, there are local advocacy services? The situation is much better than it was, but there is still an issue—and this picks up on Karen Sinclair's point, in a way—in that the most vulnerable young people are often those who are least likely to know about Childline, the National Society for the Prevention of Cruelty to Children, and the children's commissioner. To make these regulations effective, we will need to be sure that those local services are in place so that children can access them.

[153] **Rhodri Glyn Thomas:** Yr wyf yn barod i dderbyn pwyntiau cyffredinol o eglurhad. Fodd bynnag, o ran tegwch i'r Gweinidog, mae trefn o ran cael pwyntiau o eglurhad. Os ydych eisiau codi pwyntiau penodol o eglurhad, buasai o fantais i'r pwyllgor pe bai'r Gweinidog yn cael rhybudd

Rhodri Glyn Thomas: I am willing to accept general points of clarification. However, in fairness to the Minister, there is a procedure as regards points of clarification. If you wanted to raise specific points of clarification, it would be of advantage to the committee if the Minister were given prior

blaenorol, fel y gall wneud ymholiadau. Fodd bynnag, yr wyf yn siŵr, Weinidog, y gallwch ddelio â'r pwyntiau cyffredinol hynny sydd wedi cael eu codi.

notice, so that he could make enquiries. However, I am sure, Minister, that you will be able to deal with the general points that have been raised.

[154] **Brian Gibbons:** Yes, we can deal with some of the points, and I can maybe ask Ken to fill in, just to deal with the advocacy.

[155] I believe that the regulations specifically mention advocacy, and the requirement under the regulations for care homes to draw to the attention of anyone who is using the complaints procedure the fact that an advocacy provision may be available now. There is no statutory right to advocacy in several instances yet. However, as I understand it, for children complaining in a social services context, there is a statutory right, although I do not believe that these regulations cover children. However, there would not be a statutory right in the same way, apart from where the regulations specifically refer to drawing the complainant's attention to their right, or their option, to avail of advocacy services. If the care provider did not do that, particularly in a context of when advocacy services might be available, then they could be subject to criticism for not complying with the regulations.

[156] This move towards a risk-based approach and a proportionate sense of inspection does not just affect the CSIW—it is right across, from the Food Standards Agency Wales through to everything else. No-one is saying that this is the end of inspection completely; it is just that, where the inspection process can demonstrate that the mainstream of all providers is doing nothing but providing a good service, then the ongoing inspection of those organisations will be fairly arm's length, and proportionate to the fact that they are providing a good, conscientious service to their service users. However, where there are question marks—in other words, where there is a grey area, or where the situation has moved beyond the grey area—that is where the effort will be concentrated. This is the right approach. I understand your points, in that this light touch will then allow some people to try to slip under the net. However, the proportionality of it is that those people in the grey area will be subject to increased surveillance, compared with the people whose inspection has been, if you like, exemplary in many ways.

[157] I do not know whether Ken would want to comment on that.

[158] **Mr Alexander:** The self-assessment process is also being considered by other Assembly inspectorates. Self-assessment does not necessarily mean that it is a light touch, because CSIW will be looking at those as part and parcel of its overall inspection process. That will enable CSIW to target specifically those areas at higher risk. We will also be able to take a general view on self-assessments, and to ensure the specific training, to ensure that the quality of the self-assessment, which is fundamental to the process, is there. That is integral to the whole inspection process.

[159] **Rhodri Glyn Thomas:** Diolch yn fawr. Cawn doriad yn awr; mae coffi ar gael yn y Cwrt. Byddwn yn ailymgynnull am 11.25 a.m. i ystyried yr adolygiad o wasanaethau canser.

Rhodri Glyn Thomas: Thank you. We will have a break now; coffee is available in the Cwrt. We will reconvene at 11.25 a.m. to consider the review of cancer services.

Gohiriwyd y cyfarfod rhwng 11.10 a.m. a 11.26 a.m.
The meeting adjourned between 11.10 a.m. and 11.26 a.m.

Adolygiad o Wasanaethau Canser
Review of Cancer Services

[160] **Rhodri Glyn Thomas:** Croeso'n ôl. Yr ydym yn falch bod Dr Andy Fowell yma. Ef yw cadeirydd y grŵp arbenigol a sefydlwyd i'n cynghori ni ar y mater hwn. Bwriad y sesiwn hon yw edrych yn ôl dros y dystiolaeth ysgrifenedig, a hefyd ar flaenoriaethau ac amserlen yr adolygiad. Yr awgrym, erbyn hyn, yw ein bod yn ceisio cyflwyno'r adroddiad yn y gynhadledd ganser, a ohiriwyd o fis Hydref tan fis Chwefror, sydd i'w chynnal yng Nghaerdydd. Mae'n ymddangos yn lle priodol iawn i gyhoeddi'r adroddiad, ac er ei bod yn gosod amserlen dynn arnom, yr wyf yn hyderus bod modd gwneud hynny. Wrth gwrs, unwaith y byddwn yn cyrraedd mis Mawrth a mis Ebrill, bydd pethau eraill ar y gorwel, ac efallai y byddai'n well inni geisio cael yr adroddiad yn y sector cyhoeddus mor fuan ag y bo modd.

Rhodri Glyn Thomas: Welcome back. We are extremely pleased to have Dr Andy Fowell with us. He is the chair of the specialist group established to counsel us on this matter. The intention of this session is to look back over the written evidence, and also to consider the review's priorities and timetable. It has since been suggested that we try to present the report at the cancer conference, which was postponed from October until February, and which is to be held in Cardiff. That seems to be the most appropriate occassion on which to present the report, and although it sets us rather a tight timetable, I am confident that that is achievable. Of course, once we will have reached March and April, there will be other things on the horizon, and perhaps it would be better for us to try to ensure that the report is in the public domain as swiftly as possible.

[161] Nodaf hefyd fod dau gyfarfod wedi eu clustnodi, ar 13 Rhagfyr a 25 Ionawr, ac mae'n rhaid i aelodau'r pwyllgor hwn gadarnhau eu bod yn hapus i gynnal y cyfarfodydd hynny yn breifat. O ran egwyddor, yr wyf yn gwrthwynebu cynnal cyfarfodydd preifat; mae'n well gennyf eu bod yn gyhoeddus, ond, mae'n debyg, pe byddem yn cynnal y rheini'n gyhoeddus, byddem yn rhagdybio'r adroddiad ei hun yn ein trafodaethau. Felly, awgrymir y byddai'n fwy pwrpasol inni gynnal y rheini y tu ôl i ddrysau caeëdig am y rheswm y bydd yr adroddiad ei hun yn gyhoeddus cyn inni ei gyhoeddi oherwydd, yn y trafodaethau hynny, byddwn yn trafod ein casgliadau terfynol ar gyfer yr adroddiad.

I also note that two meetings have been earmarked, on 13 December and 25 January, and committee members must confirm that they are happy to hold those meetings in private. In principle, I oppose meetings being held in private; I would prefer them to be held publicly, but it appears that if we were to hold them in public, we would presuppose the report itself in our discussions. It has therefore been suggested that it may be more purposeful for us to hold them behind closed doors for the reason that the report would otherwise be made public before we could publish it because, in our discussion of it, we would discuss our final conclusions for the report.

[162] **Helen Mary Jones:** I do not understand why that is a problem, or why the public cannot see us discussing those—

[163] **Rhodri Glyn Thomas:** It is because we would pre-empt the report, I am told.

[164] **Helen Mary Jones:** Well—

[165] **Rhodri Glyn Thomas:** I am in the committee's hands.

[166] **Helen Mary Jones:** I will not die in a ditch over this matter, Chair, but I do not see why it is damaging for the public to see that there are different points of view, and that we discuss issues and come up with priorities. If it is, and other people feel that it is, then I am

not going to make a huge fuss about it, but I always think that, if I were a member of the public, especially, perhaps, if I were somebody who had given evidence to an inquiry such as this, I would wonder why I am not allow to see the discussions.

[167] **Rhodri Glyn Thomas:** I did question that myself, when I was informed, but I was told that this is the way in which committees conduct the business. I do not recall that myself, having chaired a number of reviews, now, but—

[168] **Helen Mary Jones:** That is certainly not how the Environment, Planning and Countryside Committee conducted its reviews when I sat on that committee. I cannot remember any further back than that.

[169] **Rhodri Glyn Thomas:** I do not want to prolong this discussion. Obviously, Helen has strong views on this matter; does anybody else has any views?

[170] **Helen Mary Jones:** If other people feel strongly the other way, I am not—

[171] **Rhodri Glyn Thomas:** I understand that.

[172] **Jenny Randerson:** As a matter of principle, I would prefer to meet in public.

[173] **Rhodri Glyn Thomas:** So would I, but I am in Members' hands in this matter. There is nothing to stop us from holding these sessions in public; it is a suggestion that this is apparently the way in which other committees have approached reports. However, that is not my recollection.

11.30 a.m.

[174] **Helen Mary Jones:** Would not that be wrong anyway, even if they have?

[175] **Jonathan Morgan:** I suppose that the one slight problem that we could have if we were doing this in public is that, presumably, members of the public attending the committee would have access to the paperwork so, in essence, we could be agreeing the recommendations of the report and we then end up launching it. Well, if people already know what we have decided, so what? That is the minor difficulty, namely that people would have access to the documentation. They would have to have that, would they not, if it was a public meeting?

[176] **Rhodri Glyn Thomas:** That is the rationale behind holding them in private.

[177] **Jonathan Morgan:** I can see the value of discussing ideas, conclusions and the evidence in public, but I suppose that then, if you were to finalise the recommendations for a committee report, there would be no point in launching it. In effect, as soon as you have finalised it in public committee, you have launched it.

[178] **Rhodri Glyn Thomas:** If the committee is held in public, then all the documentation is available to the public; that is a matter of course. So, I take it that we are all making the point that we would prefer, in principle, to have them in public, but we accept that, because of this, they have to be held in private. Are you happy with that?

[179] **Helen Mary Jones:** No, but I will accept it.

[180] **Rhodri Glyn Thomas:** Diolch. Yr oedd angen eglurhad. Yr wyf yn cydymdeimlo yn llwyr â'r hyn sydd wedi'i

Rhodri Glyn Thomas: Thank you. Clarification was required. I sympathise entirely with the views expressed, but there is

ddweud, ond mae pwynt yma o ran prótocol ac a fydd papurau ar gael i'r cyhoedd, a fyddai'n gwneud yr holl broses o lansio a chyhoeddi'r adroddiad yn ddibwynt.

a point here in terms of protocol and whether papers will be available to the public, which would make the whole process of launching and publishing a report pointless.

[181] Yr wyf am ofyn i Andy ein harwain yn y sesiwn hon. Mae wedi cael cyfle i edrych ar y dystiolaeth ysgrifenedig, fel yr ydym i gyd. Yr ydym yn diolch am y crynodeb a gawsom, a oedd yn ddefnyddiol iawn. Mae wedi ein harbed rhag darllen drwy'r holl dystiolaeth, ac mae'n ein galluogi i flaenoriaethu'r hyn a gyflwynwyd. Andy, a wnewch chi ein cymryd ni drwy'r dystiolaeth fel yr ydych chi yn ei gweld?

I will ask Andy to lead us in this session. He has had an opportunity to look at the written evidence, as have we all. We are grateful for the summary that we were given, which was most useful. It has saved us from having to read through all the evidence, and it has allowed us to prioritise what has been presented. Andy, would you like to take us through the evidence as you see it?

[182] **Dr Fowell:** We have had all the paperwork and, as you will be aware, there is quite a lot of it. We had 36 responses to consider from organisations and individuals, and the expert reference group met the week before last to go through those and to generate some ideas and themes to bring back to you. We must register our thanks to all the people who took the time and effort to fill in the form that you distributed fairly widely. It has generated a lot of data, and it has been very helpful. There were no responses that were off the wall; they were all very useful and sensible. Is that a polite way of putting it? I see that it is. [*Laughter.*]

[183] It allows us to develop themes, and that is what the group spent the session the other week doing; we are grateful to you for allowing us to do that. Although many of the responses were critical of present structures and systems, many were complimentary and recognised that there is a lot going on in Wales that is of a very high standard. I would like to point those out before we move on to the other section.

[184] It is recognised that research in Wales and the implementation of research findings across Wales in terms of oncology are very good. The Welsh cancer trials network and the newly formed Wales cancer bank are at the forefront of world services in this. Having said that they are good and at the forefront, I know that they would say that they still need more funding and so on. Just because something is leading, it is important that we do not divert money away from it.

[185] Most of the responses were also very complimentary about the way in which we are organised in Wales with the cancer networks, the cancer services co-ordinating group, and what has happened over the past few years in terms of developing multidisciplinary team working. That was commented on as being very good.

[186] There were comments about the networks regarding what their function was. I know that we have been through a review of the networks by Health Commission Wales not so long ago, but there still seems to be some confusion about their role.

[187] If the vision is to develop a world-class service in health for Wales, and if we then take that down to developing a world-class service for cancer patients, there are areas that we need to look at. The responses have, quite rightly, highlighted many areas where we are doing something but we could do a lot more, and we could make things happen. I will go through these in terms of themes. We have in the Cancer Network Information System Cymru—otherwise known as CaNISC—the start of an IT system that could be exceedingly useful and helpful to health professionals, but could also have an effect on improving the care across the boundaries of patients. We felt that, with development, this could be a world-class system. We are very keen that the comments in the responses are followed up on that one.

[188] We also received an almost uniform response on the state of commissioning cancer services in Wales. I gather that you have been discussing brachytherapy this morning. We had a lot of responses about this, and many were about the seemingly confused system that we have at the moment. There was a feeling that this could be done in a more structured and sensible way. Many people commented that they were not clear whether they were looking to the local health boards or to Health Commission Wales to commission services. If they were looking to the LHBs, they did not have the expertise required to commission effectively. This recognises that cancer services are complicated, are changing quickly, and are quite difficult to keep an eye on.

[189] One of the other big issues, which affects politicians and commissioners quite a lot, was how to deal with new and expensive techniques for treatment—and you have talked about brachytherapy this morning—and the new and expensive drugs that are coming at us very quickly. These new treatments are effective and are making a difference, and they will make a difference to the outcomes of patients who have cancer, but how do we make an assessment and get them into practice quickly? An important issue that came out of one or two of the responses was how to engage the public in what it wants from its cancer services. Does the public want the latest drug that might make the difference, or want the important care and support through treatment? There are choices that need to be made on this. If we are working with a budget, how will we make these decisions? At the end of the day, we need to go back to the public and say, 'What do you want to do about this—do you want to have the latest whizzy treatment, or do you want to see everyone getting a high standard of care?'. So, there is work that we need to do on that one.

[190] Following on from that theme, many of the responses were about supporting patients through their care. In its response, Velindre Hospital made it clear that the vast majority of its specialist nurses and supportive care staff are funded through charities. If the charities were to withdraw funding for those, their service would be in a poor state.

[191] Looking at the voluntary services, a lot of pressure is put on politicians about the funding of hospices in particular, and I would like it if one of the themes that went forward addressed that problem about how to fund voluntary services and make it equitable. At the moment, even in north Wales where I work, some services are funded to a higher extent than others, and there is no rationale behind that. It is historical and there is no service level agreement—these are block grants that are made. On the other hand, there is no commissioning and no management of the system either. Looking to the future, we would envisage an integration of the services, done in a sensible way.

11.40 a.m.

[192] That brings me on to a subject that was not covered in the questions that you sent out, namely how do we help people to live well with cancer? Cancer is becoming a chronic disease. If you look at breast cancer over the past 10 years, you will see that it has changed dramatically from being a condition with a terminal diagnosis to one where someone can look forward—and I think that 'look forward' is the right phrase—to many years of relatively healthy living, while still needing treatment and support through that treatment. That is an important issue. How do we help people to live well with cancer? Again, from the user's perspective, we felt that that was important.

[193] There are items within the supportive theme, and one thing that we considered, in the meeting a few weeks ago, was psychological support across Wales. We found it difficult to fund or engage psychological support for cancer patients, but it is in the National Institute for Health and Clinical Excellence guidance. The guidance on supportive and palliative care is quite clear that those patients should have access to psychology services. There is a lot in the

guidance on supportive and palliative care that could be implemented, but it is a big agenda and quite difficult to address.

[194] Finally, one thing that came up quite often in the responses was the lack of a cancer plan. Various documents have been published—going back to the Cameron report, seven or eight years ago; there is no problem on that—but we do not have an up-to-date cancer plan as some other countries do, where we could say, 'This is what we are going to do'. One of the problems with that is that there is no point in having a strategy if we do not have an implementation plan to go with it. That is the important thing. I would be loath to develop another strategy document, but not have the teeth to say, 'This is what we are going to do and this is what we are going to implement in the future'. Thinking about how we do that, and how we look to the future, I think that a cancer plan would be very important.

[195] **Rhodri Glyn Thomas:** Diolch, Andy, yr oedd hynny'n ddefnyddiol iawn. Yr wyf wedi nodi'r saith thema a gobeithiaf y gallwn wneud rhywfaint o waith arnynt a pharatoi argymhellion. Gan gymryd pwynt Andy, nid oes dim pwrpas i ni, fel pwyllgor, gyflwyno argymhellion nad ydym yn credu bod modd i'w gweithredu. Gobeithiaf nad ydym yn y busnes o gyflwyno rhestr o ddymuniadau a dyheadau gan wybod nad oes modd eu gweithredu, neu byddem yn codi gobeithion pobl yn ddi-sail a byddai hynny'n arwain at siom a dadrithiad ar eu rhan. Mae digon o feysydd yn y fan hon.

Rhodri Glyn Thomas: Thank you, Andy, that was very useful. I have noted the seven themes and hope that we can do some work on them and bring forward recommendations. Taking Andy's point, there is no point in our making recommendations, as a committee, that we do not believe can be implemented. I hope that we are not in the business of drawing up lists of hopes and dreams that we know cannot be implemented, or we would be raising people's expectations unnecessarily and that would lead to disappointment and disillusionment on their part. There are plenty of issues here.

[196] Y cwestiwn cyntaf yr wyf am ei ofyn i chi, fel pwyllgor, cyn gofyn am eich sylwadau cyffredinol, yw a oes unrhyw beth yr ydych yn credu nad yw wedi ei nodi yn y saith thema? Maent yn cynnwys systemau technoleg gwybodaeth; comisiynu; triniaethau a chyffuriau newydd sy'n dod ar y farchnad ac, yn bwysig iawn, sut i sicrhau bod trafodaeth gyda'r cyhoedd ynglŷn â hwy; cynnal cleifion ac ariannu hynny, i raddau helaeth drwy gyfraniadau elusennol; a sut y mae modd cael cysondeb o ran cyllido'r sector gwirfoddol, gyda hosbisau ac elfennau eraill yn rhan o'r gwaith. Mae cwestiwn hefyd ynglŷn â sut i gynorthwyo pobl i fyw yn dda gyda chanser. Cyfeiriwyd yn benodol at wasanaethau seicoleg ac at y diffyg mawr, sef y diffyg cynllun canser. A oes rhywbeth ar goll o'r rheiny?

The first question that I want to ask you, as a committee, before I ask for your general comments, is whether you think that anything is missing from the seven themes? They include: information technology systems; commissioning; new treatments and drugs that come onto the market and, importantly, how we ensure a dialogue with the public on them; supporting patients and funding that, to a great extent through charitable donations; and how there can be consistency in terms of funding the voluntary sector, with hospices and other elements playing a part. There is also the question of how we can help people to live well with cancer. There was a reference to psychology services and to the big weakness, which is the lack of a cancer plan. Is there anything else missing from that list?

[197] **Helen Mary Jones:** I do not think that it needs to be a separate theme, but I would like to see this running through. I am picking up on some of the summaries of the responses, for which we are very grateful, about services for children and young people, particularly the issue of what happens if you begin in or are picked up by paediatric services—this picks up on what Andy said about people living with cancer as a condition. You can be picked up by paediatric services, but you cannot necessarily assume that you are cured. I think that there is a gap in that transition between adult and children's services. Fortunately, it does not affect a

large number of young people, but we might want to have how we ensure that children and young people get their services as a cross-cutting theme running through the seven, as well as how they get the support that they need, because it is difficult enough being an adolescent, but being an adolescent dealing with a traumatic illness is even worse.

[198] **Rhodri Glyn Thomas:** Byddwn yn derbyn tystiolaeth llafar wrth staff o Claire House, sydd yn delio'n benodol gyda phlant a phobl ifanc, a gobeithio y byddant yn gallu rhoi rhywfaint o oleuni inni ar hynny. Yr wyf wedi rhoi hynny, ar hyn o bryd, yn sector 4, lle yr ydym yn sôn am gynnal cleifion, gan fy mod yn meddwl ei fod yn gorwedd yno, ond derbyniaf y pwynt y dylai fod yn torri ar draws y saith i gyd.

Rhodri Glyn Thomas: We will be receiving oral evidence from the staff of Claire House, which deals specifically with children and young people, and, hopefully, that will shed some light on the issue for us. I have put that, at present, into sector 4, where we discuss patient support, as I think that it fits there, but I accept the point that it should run through all seven.

[199] **Jenny Randerson:** It is not an omission from the list; it is about how the proposed two dates for when we will take evidence fit with that list. I know that we cannot take evidence from everyone, so I am simply asking Andy whether he selected these organisations because of the way in which they plug gaps in the evidence, or because they provide particularly pertinent evidence, or perhaps because he feels that we have plenty of evidence on some of the themes. It seems to me that some of the themes are not strongly brought out by the organisations coming to see us, so it may be that they are coming to give more general evidence. I am asking about the rationale for this, really.

[200] **Rhodri Glyn Thomas:** Yr oedd yn gyfuniad. Derbyniom awgrymiadau oddi wrth y grŵp arbenigol ond cawsom gyfle yn y cyfarfod diwethaf i ychwanegu ein hawgrymiadau ni, felly cyfuniad yw. Yr wyf yn credu ein bod wedi ychwanegu un neu ddau o dystion llafar i'r sawl a awgrymwyd gan y grŵp.

Rhodri Glyn Thomas: It was a combination; we accepted suggestions from the expert group, but we had an opportunity, at the previous meeting, to add our suggestions, so it was a combination. I think that we added one or two witnesses to give evidence to the suggestions of the group.

[201] **Dr Fowell:** When I saw the list of people to be invited, I recognised quite a few of the names, but some were not ones that we had put forward. There is a huge problem in that we only have two sessions, and we already have a very wide agenda and I am a little worried about how we will cover that in those two sessions. I am rather worried about that one.

[202] **Jenny Randerson:** I am, too.

[203] **Rhodri Glyn Thomas:** Byddwn yn pwyso'n go helaeth ar y grŵp arbenigol, sydd yn gynrychioladol iawn o'r hyn sy'n digwydd gyda gwasanaethau canser ledled Cymru. Yr wyf yn credu y byddem i gyd yn cytuno y byddai dau sesiwn arall yn ddefnyddiol, ond, yn anffodus, nid yw amser yn caniatáu hynny—nid dim ond oherwydd hyd yr adolygiad, ond mae mater bach o etholiad ym mis Mai. Mae pawb a gafodd wahoddiad wedi ei dderbyn heblaw am Gydffederasiwn y Gwasanaeth Iechyd Gwladol yng Nghymru, sydd yn methu dod i'n cyfarfod nesaf.

Rhodri Glyn Thomas: We will be heavily dependent on the expert group, which is very representative of what is happening in cancer services throughout Wales. I believe that we would all agree that another two sessions would be useful, but, unfortunately, time does not allow for that—not just because of the length of the review, but there is the small matter of an election in May. Everyone who was invited has accepted, apart from the National Health Service Confederation in Wales, which cannot attend our next meeting.

[204] **Helen Mary Jones:** Again, it is about a lack of time. Most of these organisations are highly professional, made up of highly professional individuals. We are not talking about members of the public. In that context, because we are so short of time, I suggest that we ask each of them to submit written papers in advance, that they do not give presentations, and that we simply ask them questions about what we already have. I think that that is good practice anyway. It is different from the work that the Committee on Equality of Opportunity has been doing with young disabled people, where we need to let them speak directly to us, but when we are talking about professional bodies and organisations, we could save time and have more useful sessions if, instead of listening to presentations, we did the reading in advance and spent committee time picking out the issues that we are concerned and worried about.

[205] I know that, when I have raised that with some Chairs, they have said that perhaps that is not very courteous, but I think that it is, and that it would be more useful to the organisations to have a chance to respond to some of the things that we are worried about. If we are in a situation where we have written evidence, where one group of people is saying one thing to us and another group is saying another, we will be able to unpick that, rather than spending those hours listening to presentations, when, in terms of the simple information, we ought to be able to get it on paper.

11.50 a.m.

[206] **Rhodri Glyn Thomas:** Mae pawb sydd yn dod i gyflwyno tystiolaeth yn y pwyllgor hwn yn cael cyfarwyddiadau manwl gan yr ysgrifenyddiaeth y bydd yr Aelodau'n darllen y papurau sydd wedi'u cyflwyno ac nad oes disgwyl—ac na fyddem yn caniatáu—iddynt ddarllen y dystiolaeth honno.

Rhodri Glyn Thomas: Everyone coming to present evidence in this committee receives detailed guidance from the secretariat telling them that Members will read the papers submitted and that they will not be expected or allowed to read that evidence.

[207] **Helen Mary Jones:** I think that they know that, but once you invite someone to make introductory remarks, how are they supposed to choose which introductory remarks to make? Would it not be simpler for you to welcome them and for us to ask questions? Otherwise, it becomes difficult because you have some people who give introductory remarks that take 10 minutes and others that give introductory remarks that take two minutes. I just think that we should say that there is no need for introductory remarks. You should do the introductions and tell us who they are, Chair, and then we can ask them questions. I would not necessarily be suggesting this had we four or six sessions in which to take evidence, but we have not; we have two evidence-taking sessions. I would be really concerned that we get to a point where we might get through half a list in some of these.

[208] **Rhodri Glyn Thomas:** Gallaf weld bod cefnogaeth i hynny ac fe sefydlwn y drefn honno. Ni fydd sylwadau agoriadol gan y cyflwynwyr. Fe dderbyniwn y papurau ac awn yn syth i gyfle i Aelodau ofyn cwestiynau neu wneud sylwadau. Fe gynhaliwn y drafodaeth ar sail hynny.

Rhodri Glyn Thomas: I can see that there is support for that and we will follow that arrangement. There will be no introductory comments by the presenters. We will receive the papers and move immediately to an opportunity for Members to ask questions or make comments. We will conduct the discussion on that basis.

[209] **Dr Fowell:** Could I also make a suggestion? The expert reference group would be happy to address specific questions and to prepare papers in advance for you. It may just be one side of A4 on some of these issues to raise the subjects. Can I also make a plug for a bulletin board that we have set up for the committee? In suggesting it, I thought that we could have a dialogue going on between members of the expert reference group and the committee,

and that questions could be raised and discussed, almost, and for it to be suggested that maybe we could ask someone else to give us some advice on that one, and to come back with ideas. It is about evolving a process, rather than saying, 'We are all going to do this on such and such a day and come up with a conclusion'. Over the next few months, we could have a conversation that would inform this process more than just having one sheet of paper from one organisation at a time.

[210] **Rhodri Glyn Thomas:** Croesawaf hynny'n fawr iawn. Credaf y byddai'n ddefnyddiol.

Rhodri Glyn Thomas: I welcome that very much. I think that that would be useful.

[211] **Ms Lloyd:** This is just a suggestion, Chair, but on 15 November, you are talking about the drugs and therapies and their introduction, and one of your main themes. As the Minister has reported before, we have revised the way in which new drugs are introduced and there is horizon scanning. We have been helped enormously by the all-Wales medicine strategy group, rather than NICE, all being complimentary to NICE in that. Would it be helpful if we were to outline to you how NICE and that group interface, and how we manage these things? You can then decide whether or not you need them to give you more evidence, or whether it is clear.

[212] **Rhodri Glyn Thomas:** Byddai papur ar hynny'n ddefnyddiol a derbyniol iawn.

Rhodri Glyn Thomas: A paper on that would be most useful and welcome.

[213] **Jenny Randerson:** The Committee on Standing Orders took evidence from four academics last Monday in exactly the way in which Helen Mary outlined. We had them all in at once and they presented four very different papers. I was going to suggest that we might have some draft questions. Members did not follow them exactly in the Committee on Standing Orders meeting but they definitely addressed all of the key issues that were outlined in the draft questions. It was a very efficient way of taking evidence. We got through a lot very quickly.

[214] **Rhodri Glyn Thomas:** Credaf fod cwestiynau'n ddefnyddiol iawn yn yr ystyr hwnnw. Nid oes disgwyl i Aelodau eu darllen allan air am air, na'u defnyddio hyd yn oed. Serch hynny, maent yn ein hatgoffa o'r ystod o bynciau y mae angen inni eu trafod. Mae'n gymorth mawr i'r Cadeirydd os yw'n sylweddoli bod rhyw gwestiwn heb ei ofyn, ac felly mae modd defnyddio'r rheiny. Felly, yr ydym yn ddiolchgar am y parodrwydd i baratoi cwestiynau hefyd.

Rhodri Glyn Thomas: I think that questions are very useful in that context. Members are not expected to read them out word for word, or even use them. However, they remind us of the range of subjects that we need to discuss. It is of great assistance to the Chair if he realises that some questions have not been touched upon, and, therefore, those can be used. Therefore, we are grateful for the willingness to also prepare questions.

[215] A oes sylwadau eraill ar y broses?

Are there any other comments on the process?

[216] **Karen Sinclair:** I agree with Helen Mary. I think that that is a far more efficient way of doing things. You only have to have someone who is particularly passionate about their particular area and it is difficult, because you feel rude telling them to stop. However, on the other hand, it is taking up valuable time. On 15 November, we have palliative and supportive care, new therapies and drugs, and principles of screening. Will we take those as discrete areas, because it would be ridiculous to have all of that in together would it not?

[217] **Rhodri Glyn Thomas:** Wrth reswm, byddwn yn cymryd y rheini bwnc wrth bwnc.

Rhodri Glyn Thomas: We will, obviously, take those subject by subject. They will all be

Byddant oll yn cael eu trafod yn y cyfnod hwnnw, ond ni fyddwn yn eu trafod ar draws ei gilydd: bydd y drafodaeth yn cael ei chyfyngu i un pwnc ar y tro.

discussed during that period, but we will not discuss them at the same time: the discussion will be restricted to one subject at a time.

[218] Os nad oes sylwadau eraill, ac efallai fod Andy eisiau dweud gair i gloi, credaf ein bod wedi gwneud y cyfan sydd ei angen i ni ei wneud ar hyn o bryd, er mwyn symud y broses yn ei blaen. Buaswn yn ein hannog ni i gyd i gymryd mantais o'r broses hon y mae'r grŵp arbenigol wedi ei roi yn ei le sydd yn caniatáu inni gael y drafodaeth barhaus hon—unwaith y byddwn wedi gweithio allan y dechnoleg er mwyn gwneud hynny, ac fel rhywun nad yw'n deall y dechnoleg yn arbennig o dda, mae'n siŵr y gall rhywun fy nghyfarwyddo. Bydd y drafodaeth honno yn fuddiol iawn. Andy, a ydych eisiau gwneud unrhyw sylwadau i gloi?

Unless there are any further comments, and perhaps Andy would like to say something to close, I believe that we have done everything that we need to do at present, in order to move the process forward. I would urge us all to take advantage of this process that the expert reference group has put in place, which allows us to have this continual discussion—once we have worked out the technology that will allow us to do that, and as somebody who does not understand the technology very well, I am sure that someone can instruct me. That discussion will be very beneficial. Andy, do you want to make any closing remarks?

[219] **Dr Fowell:** As someone who is never off his BlackBerry, I find that a very strange statement. [*Laughter.*]

[220] We have started a process, and I think that we are in the middle phase. We have a lot of discussion to go on and I hope that you will use the expert reference group; it is there to be used. We are more than happy to prepare a paper on a different subject, and if we do not have the expertise within the group, we will find someone who can help us on that one. Another thing that we can do is to point people in the direction of papers that are already written, because a lot of work has already been done. We have had the review of the network systems, and Ann has mentioned that work is ongoing in the Assembly, and it is important that we do not ignore processes that are already in place.

[221] You mentioned the all-Wales medicine strategy group, and we obviously need to take account of what is already happening and to be aware of that, rather than seeing things at a set place in time. I will just mention, looking forward, that there is a meeting in Brussels in November on national cancer plans, which the Chair has suggested that I attend, which I am planning to do. Again, I would see that that is something that I would write a report on, to circulate around this group after that meeting. This is an ongoing dialogue and I would like to keep it going.

[222] **Rhodri Glyn Thomas:** Diolch, Andy. Credaf fod yr elfen hynny o ddeialog yn bwysig. Os yw Aelodau wedi bod ar ymweliadau, ac yr wyf yn gwybod fod rhai ohonoch wedi bod yn ymweld â gwahanol ganolfannau ac wedi trafod ag unigolion, a allwch gyflwyno hynny i mewn i'r broses a'r ddeialog gyda'r grŵp arbenigol? Yr wyf yn siŵr y byddent yn falch o glywed am unrhyw beth yr ydych wedi bod yn ei drafod neu unrhyw beth yr ydych wedi ei ddarganfod.

Rhodri Glyn Thomas: Thank you, Andy. I think that that element of dialogue is important. If Members have been on visits, and I know that some of you have visited various centres and have had discussions with individuals, could you present that into the process and into the dialogue with the expert reference group? I am sure that they would be very happy to hear of any discussions that you have had or any discoveries that you have made.

[223] Os nad oes unrhyw beth arall, gallwn ddwyn yr eitem hon i ben.

Unless there is anything further, we can draw this item to a close.

[224] Mae dau bapur i'w nodi: un ohonynt yw'r cofnodion, a nodi rheini yn unig yr ydym yn ei wneud erbyn hyn. Diolch yn fawr iawn i chi am eich presenoldeb.

There are two papers to note, one of which is the minutes, which we only note these days. Thank you all very much for your attendance.

[225] Wrth gloi, ategaf yr hyn sydd wedi cael ei ddweud gan nifer ohonoch. Yr ydym yn gwerthfawrogi'n fawr y mudiadau a'r unigolion hynny sydd wedi ymateb i'r adolygiad hwn ar wasanaethau canser. Yn sicr, ni fyddem wedi gallu symud ymlaen heb eu parodrwydd i wneud hynny, ac yr ydym yn cydnabod hynny ac yn ddiolchgar iawn.

In closing, I will endorse what has been said by a number of you. We very much appreciate those organisations and individuals that have responded to this review on cancer services. We certainly would not have been able to move forward without their willingness to do that, and we acknowledge that and are very grateful.

Daeth y cyfarfod i ben am 11.59 a.m.
The meeting ended at 11.59 a.m.