Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

The National Assembly for Wales
The Health and Social Services Committee

Dydd Iau, 26 Hydref 2006

Thursday, 26 October 2006

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

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

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

Swyddogion yn bresennol: Dr Tony Jewell, Prif Swyddog Meddygol; Ann Lloyd, Pennaeth, Adran Iechyd a Gofal Cymdeithasol; Kathryn Potter, Gwasanaeth Ymchwil yr Aelodau

Eraill yn bresennol: Sue Acreman, Pennaeth Datblygiad Ansawdd ac Ymchwil, Canolfan Canser Felindre; Natalie Cooper, Arolygiaeth Safonau Gofal Cymru; Dr Andrew Fowell, Cadeirydd, Grŵp Cyfeirio Arbenigol; Rob Pickford, Prif Weithredwr, Arolygiaeth Safonau Gofal Cymru.

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

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

Officials in attendance: Dr Tony Jewell, Chief Medical Officer; Ann Lloyd, Head, Health and Social Care Department; Kathryn Potter, Members' Research Service.

Others in attendance: Sue Acreman, Research and Development Quality Lead, Velindre Cancer Centre; Natalie Cooper, Care Standards Inspectorate for Wales; Dr Andrew Fowell, Chair, Expert Reference Group; Rob Pickford, Chief Executive, Care Standards Inspectorate for Wales.

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

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

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

[1] **Rhodri Glyn Thomas:** Bore da a chroeso i'r cyfarfod hwn o'r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol. Yr wyf yn eich atgoffa o'r angen, cyn cyfrannu, i sicrhau bod y golau coch ymlaen ar y meicroffon. Nid oes angen ichi gyffwrdd dim, dim ond disgwyl i'r golau coch ddod ymlaen. Gofynnaf i bawb sydd yn yr ystafell bwyllgor neu'r oriel i droi unrhyw offer electronig i ffwrdd. Nid yw'n ddigonol i'w rhoi ar ddistaw, mae angen i offer—gan gynnwys BlackBerrys—gael ei ddiffodd yn llwyr. Os bydd angen inni adael yr ystafell neu'r oriel, dilynwch y cyfarwyddiadau a fyddwch yn derbyn gan y tywysyddion.

Rhodri Glyn Thomas: Good morning and welcome to this meeting of the Health and Social Services Committee. I remind you, before you contribute, that you need to check that the red light is visible on the microphone. You do not need to touch anything, just wait for the red light to come on. I ask everyone in the committee room or the public gallery to switch off any electronic devices. It is enough to put it on silent, all devices—including BlackBerrys—must be switched off completely. If we should need to leave the room or the gallery, follow the instructions that the ushers will give you.

[2] Yr ydym wedi derbyn ymddiheuriad wrth Helen Mary Jones, sydd yn methu bod yma, ac mae Dai Lloyd yn eilydd ar ei rhan.

We have received an apology from Helen Mary Jones, who is unable to be here. Dai Lloyd is substituting on her behalf. Are there

A oes datganiad o fuddiant? Gwelaf nad oes.

any declarations of interest? I see that there are none.

9.32 a.m.

Adolygiad o Wasanaethau Canser
Review of Cancer Services

[3] **Rhodri Glyn Thomas:** Yr oeddem yn gobeithio y byddai Cydffederasiwn GIG Cymru yn gallu bod yma, ond, yn anffodus, nid yw hynny yn bosibl gan fod ei gynrychiolwyr wedi gorfod mynd i gyfarfod yn Llundain. Felly, yr ydym yn croesawu Sue Acreman, yr unig un i roi tystiolaeth y bore hwn, o Ysbyty Felindre. Yr ydym yn falch o'ch presenoldeb. Yr ydym wedi derbyn tystiolaeth ar bapur wrthoch, a gallaf eich sicrhau bydd yr Aelodau wedi ei darllen, ond os oes gennych unrhyw beth i'w ddweud fel cyflwyniad neu'n ychwanegol i'r papur, mae croeso ichi wneud hynny yn awr.

Rhodri Glyn Thomas: We had hoped that the NHS Confederation in Wales would be able to join us, but, unfortunately, that is not possible, because its representatives had to attend a meeting in London. Therefore, we welcome Sue Acreman, our sole witness this morning, from Velindre Hospital. We are pleased that you are here. We have received your written evidence, and I can assure you that Members will have read it, but if you have anything to say as an introduction or to expand on your paper, you are welcome to do so now.

[4] **Ms Acreman:** Thank you for inviting me to come here today. I am here representing the nursing and allied health professionals cancer advisory group of the cancer services co-ordinating group, although I work at the cancer centre.

[5] **Jonathan Morgan:** First, Sue, thank you for the report and for being able to give evidence to us this morning. After looking through the report, I have a number of questions to raise with you, but, looking at the recommendations that you have come up with, the first thing that struck me when I read the list was that it sounds as though this should all be happening anyway. By putting recommendations in, you are suggesting that that is not happening. Can you elaborate on why you have put in these recommendations and, if there are deficiencies in the system, where they are and what are the challenges for us to try to overcome them?

[6] **Ms Acreman:** The recommendations are there because there is no unified care across any patch in supportive care for patients with cancer. The concentration of allied health professional expertise is in the cancer centres, and we know that cancer patients spend the majority of their lives outside cancer centres, but there is no formal supportive care outside, so we are starting from a basis of zero or informal support.

[7] **Jonathan Morgan:** You said in the section on constraints that:

'The nature and level of AHP services designed to meet the needs of patients with cancer is in short supply'.

[8] In terms of having an appropriate mix of health professionals working in the system—I know that you have said that there is a mapping exercise happening at present and I think that we would be very interested to see the result of that—are there currently any particular shortages of clinicians and therapists that we would need to be aware of, perhaps within the confines of the report that we will be writing?

[9] **Ms Acreman:** I think that the mapping exercise will reveal quite clearly the shortage

that exists. If you look at the south-east Wales cancer centre and just pick dietetics, for example, you will see that there are 1.5 dieticians within the cancer centre for cancer care. Obviously, they specialise in it. Within the acute hospitals there are dieticians who will participate in head and neck clinics, for example. Outside of that, I think that there is only one dietician who works out of the palliative care centre in Aberdare, and that is reflected across Wales and across all professions. In the hospice in Penarth there are some occupational therapy and physiotherapy services; there are no dietetics, podiatry, or speech and language services.

[10] I am sorry; I should be looking at you; I do apologise.

[11] **Rhodri Glyn Thomas:** You can look at any committee member that you choose, but if you prefer to look at me, that is fine.

[12] **Jonathan Morgan:** You would only increase his vanity. [*Laughter.*]

[13] **Ms Acreman:** Therefore, we are starting from the point of asking what we need, although we are very aware that there is not a huge resource to invest. However, if you look at other sorts of rehabilitation services, such as cardiac rehabilitation, you will see that these models can be used for supportive care.

[14] **Jonathan Morgan:** Is it a question of not enough resource being identified to recruit the appropriate numbers of professionals, or is it the case that we are not training sufficient numbers, or is it a mix of both?

[15] **Ms Acreman:** I think that it is a mix. Not enough opportunities are created for AHPs to work in cancer care. There is no real formal training and education for AHPs once they have got past their undergraduate status. There is no formal cancer care, which is why we are looking, in the cancer centre, at developing a school of cancer care. However, that is another matter. There are not the experts out there. However, the basic education of the AHPs lends them to be able to take on board cancer care very easily.

[16] **Dr Fowell:** I would like to comment on that, if I may. One of the things that we have is National Institute for Health and Clinical Excellence guidance on supportive and palliative care in cancer patients. NICE has produced a large document with a lot of evidence behind it. It makes a lot of recommendations about allied health professionals, what should be the make-up of a team and so on. However, as Sue has said, one of the big problems is that there is no formal recognition of what makes a specialist in cancer care. I am delighted to hear that Velindre is looking to do something about that.

[17] **Jonathan Morgan:** To pick up this point of the school of cancer care, I think that this could be a very interesting proposal. How far down the line is the proposal and at what stage is it, if we are able to investigate that a little further without your breaking any confidences? I was very interested in what you said and I think that that could go some way, if not the whole way, towards curing the problem that you have alluded to.

[18] **Ms Acreman:** I do not know whether I am in a position to speak about it, but I think that it is hoped to have the school of cancer care up and running by September 2007. There is close working with Cardiff University, but the slight issue that we have is that dieticians and speech and language therapists are trained at the University of Wales Institute, Cardiff, so there needs to be consultation and partnership working. I do not think that I can say anything else about that.

9.40 a.m.

[19] **David Lloyd:** I commend the presentation and the written evidence that is before us. I will pursue matters a little further in terms of evidence gathering. It seems to me, from reading through the papers, that a substantial amount of commissioning of cancer treatment occurs in direct commissioning of the medical specialties and very little in what would seem to some people to be low-level rehabilitatory and supportive therapies. Certainly, that is so if the opinion of the health service commissioners at the moment is reflected in commissioning spend, at least. I am trying to develop the idea of the importance of allied professionals, particularly occupational therapists and physiotherapists, in cancer care. Your average person in the street would not necessarily associate occupational therapists and physiotherapists with cancer care, which presumably reflects some of the difficulties in commissioning that care in the first place—it seems to be highly skewed in favour of the medical specialties, oncology and so on, which is fair enough. However, with regard to the remit that we have today—living well with cancer—will you just say a little more on your feelings about the numbers of occupational therapists and physiotherapists that we need to get a substantially improved service? I appreciate that a mapping exercise is going on, and I doubt if anyone will directly quote any figures that you may choose to give, but it is important that we get a handle on what sort of hiatus we are looking at with regard to professionals in those fields to enhance the quality of provision for living with cancer.

[20] My second point vaguely follows on from that. The spiritual aspects of living well with cancer are also fundamentally important and I realise that there is a crossover between various religious institutions and hospices. In terms of trying to develop that, we must not just recognise the spiritual element as being important in how people cope with cancer, but hope to develop that aspect within health service commissioning, rather than just merely recognising that it is important and doing nothing about it. How would you foresee developments emphasising that aspect of things?

[21] **Ms Acreman:** On the numbers, I think that the mapping exercise will reveal that there are very few specialist therapists per se. If you take occupational therapy and physiotherapy out of allied health professionals, it must be said that without the input of dietetics and speech and language therapy, you will not get all-round supportive care. If a patient is not well nourished, they will not be fit enough to undertake the mobility exercises or whatever that the physiotherapists and occupational therapists recommend. Occupational therapists and physiotherapists have a low profile, but they have a higher profile than the other allied health professionals. I really would not want to confine myself to numbers, but I will just say that the expertise is concentrated in small areas within Wales. On the spiritual aspects, would it be possible for Andy to speak about that?

[22] **Dr Fowell:** I must admit that I am not sure how chaplaincy is commissioned in the NHS—I was going to say that I do not have a clue, but I will phrase it as ‘I am not sure’. All I can say is that in the hospital where I work, there is quite a strong presence. Sorry, I will rephrase that and say that it is certainly noticeable that chaplaincy takes place. I also get the feeling that it is recognised within all trusts that this takes place. How you involve that with the care of patients and identifying their spiritual needs is important. That comes down to personalities on the ground as to how much they engage with the process.

[23] Coming back to the numbers question, we have Welsh cancer standards. By 2009, we will be expected to have met those standards across Wales. Many of those standards are around posts, and how you configure services. To have, say, a fully functioning head and neck cancer service, you will need to have, and need to demonstrate that you have, the supportive services in place as well, namely speech and language and dietetics. That will be a box to tick in the measurement against the standards.

[24] Therefore, the cancer standards will be a big way of driving forward this agenda. However, I worry that the gaps are large, and filling those gaps will be difficult. It has been

quoted at me that the supportive and palliative care deficits to meet the standards by 2009 are the biggest ones that we have. Surgical services can be reconfigured, as can cancer services, and whatever. However, the supportive ones are where we have the biggest deficits. It is a rather hidden iceberg that is floating there; I do not believe that we realise how big this deficit is. This mapping exercise will be interesting.

[25] **Jenny Randerson:** You say in your evidence that there is little expertise outside the main cancer centres. You also say that not all district general hospitals have specialist occupational therapy. In your evidence, you also refer to other things, such as lymphoedema treatment, and so on. In my experience of visiting Velindre, that is not even properly and fully available there. Is the issue simply that these services are not being commissioned because they are not understood, in terms of their importance, or are they not being commissioned because there is not the money in the system, or is it because the various therapists have not yet been trained? As you will see from that latter bit, if they have not yet been trained, there is a significant time lag. However, if they are already out there, but do not have the jobs—if the posts are not available for them—it is quicker to remedy.

[26] **Ms Acreman:** It is a combination of those three factors; Dai Lloyd called them low-level rehab services. Emphasis is placed very much on clinical trials and surgery, radiotherapy and chemotherapy. Perhaps there is a lack of understanding of the role of the allied health professional in supportive care. It is a vicious circle—because there are not that many AHPs, they cannot provide the evidence of the benefit that they can provide, and, therefore, the services are not commissioned.

[27] On training, as I say, much of it would be experiential training. Your average AHP would be able to take on board the lessons and the learning that you require. Also, we are now having rotation posts—certainly in south-east Wales—between the cancer centre and the University Hospital of Wales, so that we share expertise. That needs to be rolled out across Wales, so that you provide people with experience of cancer care, so that the experts are there and that they are teaching them on the job.

[28] **Jenny Randerson:** Does the long-term answer perhaps lie in the nature of the training to begin with, so that there is more awareness?

9.50 a.m.

[29] **Ms Acreman:** I do not know whether that is the long-term answer. If AHPs were given the opportunity to show what they could do in supportive care, it would become a continuum. For example, if you take an occupational therapist or physiotherapist, they do not have a bad profile in terms of what they can do in terms of supportive care, but that is because it is done through those rehabilitation services and they can show what they can do from that point of view. I think that it is just down to getting the chance to show what we can do.

[30] **Karen Sinclair:** First, on supportive care through the allied services, presumably people who live with the aftermath of cancer treatment often just need direct contact with someone who can give them advice. Sometimes, they just need reassurance and they would find things difficult if they had to go through the complicated network of the GP and beyond. How do you see the role of the allied services in establishing direct links for people who sometimes just need to be reassured? That little bit of reassurance can alleviate a great deal of emotional trauma for people.

[31] On spiritual care, chaplains have been dispensed with, due to cost-cutting exercises, in some trusts in England. Are spiritual needs included in the care standards? I also wanted to ask about lymphoedema treatment, but should I come back to that later?

[32] **Rhodri Glyn Thomas:** Yes; we will take the first questions first. On chaplains, Ann, can you help us with that?

[33] **Ms Lloyd:** Yes, Chair. The need for spiritual support, in the community or, particularly, in hospital, is part of the guidance that we issue in the fundamentals of care programme, which is reinforced with the local health boards. To my knowledge, there is no trust in Wales that has dispensed with its chaplaincy service. Such services are extraordinarily cost-effective, because much of the time is delivered for nothing. However, we have been trying to ensure that the chaplaincy services are better supported and that the chaplains get better opportunities for training and education, particularly in terms of dealing with the range of service users that they come across in hospitals. It is a fundamental part of the fundamentals of care programme.

[34] **Brian Gibbons:** I had an opportunity to meet the college of hospital chaplains, as I think they are called. They are also members of the Amicus trade union, so they are relatively well-organised in that sense. I suppose that they are keeping their options open in terms of who will look after them best. However, having met them, I see that they provide a generic service. They are not visiting people on the basis of selling a particular religious outlook and not even a necessarily Christian or deist outlook. If people have spiritual needs, they will try to accommodate narrowly religion-based needs and they are good at offering general spiritual support in its broader sense. They are probably an underutilised and underappreciated resource in many instances. Karen is right to say that some trusts in England have decided to disinvest in such services. However, in north Wales, they are developing a network of these services. I had a chance to visit the north Wales college, and it seems to have a good network of mutual support and flexibility in terms of how it does its work.

[35] **Ms Acreman:** On Karen's question about the aftercare from AHPs, we would look at three areas. First, the AHP would provide the empowerment and the advice for the patient to be able to live independently. That would be across all AHPs. There would be no expectation that the patient or the ex-patient would have to travel back and forth. Another issue there is that AHPs can train others to provide basic care and support in the AHP field. For example, community nurses and practice nurses could be trained. AHPs are involved in promoting the independence of patients, because, after all, that is all to do with living well. Thirdly, they have a big role to play in health promotion. I think that the statistics show that 58 per cent of cancer survivors are living more than five years now, but they are still at risk of other diseases. So, AHPs can promote healthy living through diet, exercise and lifestyle changes.

[36] **Dr Fowell:** On reassurance, going back to the NICE guidance on supportive care, one of the recommendations is that each cancer patient should have a named health professional who will be their first point of call for problems. That might be a specialist nurse in the field, an AHP, an occupational therapist or a physiotherapist. That is one of the recommendations that we have not yet been able to introduce across Wales—that concept that a patient will have a named person, throughout their illness, who will be their point of contact and someone to turn to when they need reassurance, whether during or after treatment. That person may change as the patient progresses. It may be a specialist nurse during the treatment phase, and then it may be a district nurse, a Macmillan nurse, a practice nurse or, as the patient progresses past treatment to the point where they are living with having been treated, it may be their GP. To return to spiritual care, there is one tick box in the cancer standards for palliative care that requires the team to have links with a chaplaincy.

[37] **Karen Sinclair:** On the subject of chaplaincy, people often find it very difficult to discuss their emotional needs with their partners, because they feel that they are burdening them. Sometimes, a totally detached ear can be so useful and precious. People share protection; they protect their partners and their partners protect them. Therefore, they can end up going around in circles and not finding the release that they need.

[38] What I was exploring on the issue of supportive care through allied services was whether there should be some sort of post-treatment self-referral system. I wondered whether people should be able to pick up the phone and call—not just one named person—to link in to the whole area of expertise.

[39] I also wish to ask about lymphoma treatment, which is obviously very important for women who have had breast cancer treatment. You talk about lymphoma treatment in your paper. It can be a difficult area. In Wrexham at one time, our lymphoma nurse was based in the hospice. She was doing a jolly fine job, but she was the only person we had who was a specialist in that area. Where do you envisage lymphoma treatment coming from? Who are the best people to deliver that—nurses, physiotherapists or someone else?

[40] **Ms Acreman:** May I just confirm that you are talking about lymphoedema, rather than lymphoma?

[41] **Karen Sinclair:** Yes, lymphoedema. I am sorry. I should have said swelling of the arm, as that is how I understand it.

[42] **Ms Acreman:** I would not be able to talk about lymphoma. Lymphoedema practitioners can be nurses, physiotherapists or occupational therapists. Across Wales, there is a good mix of nurses and physiotherapists who provide that care. I know that lymphoedema is quite a big issue at the moment. I wanted to include it in the paper, because, as you rightly say, it is a very life-limiting issue, mainly for ladies with breast cancer, but for people with other tumour sites too.

[43] **Karen Sinclair:** When you do your mapping exercise, will you look at that too?

[44] **Ms Acreman:** We can do. The survey questions are a little more basic than that. Because the surveys will be going to non-specialist areas such as district general hospitals and acute hospitals, we are asking, for example, how many physiotherapists specialise in cancer care. We are also looking at physiotherapy assistants across all the allied health professional services. We will do it via the Welsh Therapies Advisory Committee, which will be the conduit for the survey. We will then ask how many formal and informal services they provide for cancer patients. We were not going to go down the route of lymphoedema, because it has been reviewed quite recently.

10.00 a.m.

[45] **Dr Fowell:** Sue is quite correct. There was a review of lymphoedema services a couple of years ago, and a recent paper reviewing that review to see what progress had been made. The Welsh Association of Lymphoedema Services is aware of who is working in this field in Wales, and it is quite active, as Dr Gibbons knows; they have banged on his door on quite a few occasions.

[46] Going back to Jenny’s question, one issue for lymphoedema is that it is not understood by commissioners. It is a little bit of a cinderella service, and it takes two years’ training to get someone fully trained to deal with lymphoedema. It is quite an investment of time and effort to get someone fully trained, and then you have problems retaining that person once they are trained, so there is an issue there. Although it covers cancer patients who need this service, and you quite rightly mentioned women who have had mastectomies and who get swollen arms, there is also a pool of people in the community who have had lymphoedema from birth, as it is a congenital condition for some people, and, although they are small in number, they can swamp a lymphoedema service, as it can take a lot of time and effort to treat them. There is an issue for most lymphoedema services in how they deal with the cancer

patients' needs as well as this other cohort of people who have great needs. That balance is difficult.

[47] **Ms Acreman:** On Karen's question about empowerment and aftercare, lymphoedema patients can be taught a certain level of self care, and they can involve their nearest and dearest and family members for that. It is a good example of how therapy services can allow the patient to be independent while keeping an eye on the condition, because, if the services are overpowered, when do you discharge them? That is not the case with the other allied health professionals.

[48] **Jenny Randerson:** I wish to ask Andy a quick follow-up to his last comment. It is my understanding that, for lymphoedema services to work properly, they need to be applied punctually and rapidly. Lymphoedema gets steadily worse, but, with treatment, it can be prevented from getting worse. You mentioned tick boxes a couple of times—which reveals something for a start, I think—but is there a tick box relating to lymphoedema?

[49] **Dr Fowell:** I have just filled in a section on palliative care for my trust for the Welsh cancer standards, and I will be reviewing the breast section before the end of the month. I am not sure whether that has lymphoedema service as a tick box. Palliative care does not, I do not think. I filled it in only yesterday, but I cannot remember. Tick boxes indicate that you have a service there, but it does not tell you about the level of the service or the expertise that goes on there.

[50] **Jenny Randerson:** One hesitates to suggest that there should be any more targets in life, but, for lymphoedema and for promptness of treatment to be recognised, it needs to be up there, does it not, in terms of the standards?

[51] **Dr Fowell:** Yes. Going back to your earlier comment about the timeliness, there are some excellent projects going on across Wales, especially with breast cancer patients. In Swansea, they have organised a good system of ensuring that people do not get lymphoedema by exercise, swimming and so on, and that is to be commended.

[52] **Rhodri Glyn Thomas:** Jonathan?

[53] **Jonathan Morgan:** The question that I wanted to ask has already been answered.

[54] **Rhodri Glyn Thomas:** If there are no more questions—

[55] **Dr Fowell:** Sorry, but I just wish to make sure that we cover this fully. Sue mentioned that, across the cancer centres and the district general hospitals, there are gaps in the provision of service. I will just mention that the voluntary sector, in hospices and the services that it supplies, has quite a few physiotherapists and occupational therapists working with it, who plug many of the gaps that we have in services across Wales. It would be remiss not to recognise the input of the voluntary and charitable sector in this regard.

[56] **Jenny Randerson:** Following on from that, are they provided entirely through the initiative of the voluntary sector, or are they in any way commissioned by the national health service?

[57] **Dr Fowell:** I suspect that the voluntary service sees a gap in the service and initiates and, often, funds that service. It is not commissioned or managed via local health boards' services.

[58] **Ms Acreman:** I would just say to Jenny that the cancer centre is involved in partnership working with Marie Curie, and has rotational occupational therapy posts that have

just started.

[59] **David Lloyd:** I have a question on the review in general, but not particularly on the matters before us today.

[60] **Rhodri Glyn Thomas:** You can ask that question of Andy, presumably.

[61] **David Lloyd:** It would probably be better to ask the Minister, or you, as Chair, actually.

[62] **Rhodri Glyn Thomas:** Well, ask the question, and somebody will try to answer it.

[63] **David Lloyd:** I admit, before we start, that I am here as a substitute today, and rather an inadequate one at that, but certain representations have been made to me about where the appraisal of new cancer therapies falls. Are there any thoughts on including in this review of cancer services the means by which new cancer treatments are appraised, and would it be appropriate to have evidence from the Welsh Medicines Partnership at some point? I am looking for advice on that matter.

[64] **Rhodri Glyn Thomas:** We certainly have looked at this area within the review. We are not in a position to take any more oral evidence, as we just do not have the time; the timescale is already tight and we need to finish the review before Christmas, so that we can launch it in the new year. In addition, there is the small matter of an election pending. That all makes the timetable very tight. However, if those in the partnership want to offer additional evidence, I would be quite happy to accept it, although the consultation period is over. If you inform them that I would be happy to receive written evidence, we will then look at it.

[65] As there are no more comments or questions, I thank you very much, Sue, for coming along. I know that you were slightly apprehensive about attending the committee meeting.

[66] **Ms Acreman:** I felt a little bit clammy. [*Laughter.*]

[67] **Rhodri Glyn Thomas:** It has been a very useful session for us. Thank you for your written evidence and for your comprehensive answers to the wide-ranging questions put to you. Thank you.

[68] **Ms Acreman:** Thank you for asking me.

[69] **Rhodri Glyn Thomas:** Thanks as usual to Andy for helping us with the evidence gathering.

[70] **Karen Sinclair:** On the commissioning paper, obviously the Welsh NHS Confederation is not here today, but will there be any other point at which we will have an opportunity to speak to it? I found that to be a particularly stimulating piece of work, and it would be very sad if we did not have an opportunity to explore it.

[71] **Rhodri Glyn Thomas:** We will have to try to reschedule the evidence from the confederation. It was at very short notice that we were told that its representatives were unable to be here today, because they had to go, unexpectedly, to a meeting in London. However, we will certainly try to get that back into the schedule. Even if I cannot find time in the formal sessions, we will invite them along for a lunchtime briefing so that you can talk to them about the issue. However, I hope that we can fit that item back into the formal schedule before Christmas.

[72] **Karen Sinclair:** The only problem with an informal briefing, Chair, is how we would

feed it into our review.

[73] **Rhodri Glyn Thomas:** That would be only a second choice if we do not find the time, but I am hopeful that we can squeeze things along and find a space for them. Sue, thank you very much again.

10.10 a.m.

Adroddiad y Gweinidog
Minister's Report

[74] **Rhodri Glyn Thomas:** Yr oedd yr eitem hon i fod ar ôl y toriad ond yr ydym wedi symud ymlaen yn gynt na'r disgwyl oherwydd nad oedd Cydffederasiwn GIG Cymru yn gallu bod yma. Felly, gyda chaniatâd y Gweinidog, symudwn at ei adroddiad. A oes rhywbeth yr ydych am ychwanegu ar lafar, Weinidog?

Rhodri Glyn Thomas: This item was supposed to be taken after the break, but we are running a little early because the Welsh NHS Confederation could not attend. So, with the Minister's permission, we will move on to his report. Do you want to add anything to the written report, Minister?

[75] **The Minister for Health and Social Services (Brian Gibbons):** In item 11, we mentioned bone marrow transplants. I should have put in a little bit extra about the good work that the Welsh Bone Marrow Donor Registry is doing. Wales has taken a lead in this. The registry has made tremendous progress and it is probably one of the best marrow transplant registers in the world. I was at one of its events at City Hall or the museum in Cardiff to celebrate, I think, its first 10 years. However, in the context of bone marrow transplants, we should take particular pride in it in Wales, and we should thank the people working in that service for the excellent work that they are doing.

[76] **Rhodri Glyn Thomas:** Daeth y datganiad yr wythnos hon am yr achos llys yr oedd Cymdeithas Genedlaethol Goruchwylwyr, Dirprwyon a Saethwyr Glofeydd wedi'i ymladd o ran gweddw un o'i aelodau o ran costau gofal nyrsio. Deallaf eich bod yn gwneud datganiad ysgrifenedig yfory am y mater hwn. A oes unrhyw beth y gallwch ei rannu gyda ni y bore yma?

Rhodri Glyn Thomas: There was a statement this week about the court case that the National Association of Colliery Overmen, Deputies and Shotfirers has brought on behalf of the widow of one of its members, over the costs of nursing care. I understand that you will make a written statement tomorrow on this matter. Is there anything that you can share with us this morning?

[77] **Brian Gibbons:** I am happy to do that. The NACODS case dates back a number of years, to 2002, and it is one of the cases that have gone through the Powys Local Health Board appeal mechanism. A couple of hundred have gone through that system already, and several millions of pounds have been given out in compensation to people who may not have had a proper assessment. I think that that may have been the basis of some of the ombudsman's concerns, which we have discussed in Plenary and in this committee. I am not trying to diminish the importance of the findings in relation to the family of the person involved but it goes back several years. Since then, we have responded and have issued the guidance in response to the ombudsman's report.

[78] The nursing workbook was also issued. In the next couple of weeks, in light of the Grogan case, which is a sort of an update on the findings in the case of Coughlan, we are issuing further guidance and advice to the health service, updating the guidance that was issued following the ombudsman's report. The workbook is also being updated for the nurses

who do the assessment, to take into account some of the developments of the Grogan judgment, and we are also hoping to set up a joint group between social services and local health boards so that there will be some consistency, or a semi clearing house, of ideas and approach in dealing with continuing NHS care.

[79] I have reported before that everybody in a care setting—a care home or even a nursing home—should have an annual check-up or re-assessment of their current status. If there has been any change in their circumstances, that assessment will be used to identify it proactively. Equally, the statement will say that if people feel that they may be eligible—and this case may bring it up for people who may not have been aware of it before—either they or their close relatives should contact their local health board.

[80] So, there is a fair amount of work going on to try to ensure that the system is much more robust and proactive, and that the people using it are more informed. Having said that, and having taken a fair bit of advice on the Grogan case, it is still fiendishly complicated and to find your way through what some of the legal terminology means is extremely difficult. That is one reason why we are getting these cases. I am not a lawyer and I do not want to disparage the judicial system, but, to me, some of the interpretation and the language is pretty opaque, and there must be plenty of mileage in it for the legal profession in terms of further elucidation and clarification of what is intended, with all due respect to my colleague on my left, John Griffiths.

[81] **David Lloyd:** On this issue and the NACODS victory this week, which potentially has huge implications all round, may I press you a little further on the nursing assessment aspect, the eligibility criteria and the complexities involved, which you have just mentioned? I realise that there is a nurses' workbook, but the situation requires clarity and a single set of eligibility criteria in terms of nursing care. What progress is there on that work to make it clear what the eligibility criteria are for nursing vis à vis personal social care? I do not want to get into the whole debate about what constitutes personal social care and what constitutes nursing care again—philosophically, I have problems with that artificial divide in any case. However, where are we now on a single set of clearly defined eligibility criteria for continuing nursing care, so that people suffering from Alzheimer's disease do not feel that they are discriminated against when it comes to the provision of nursing care, which is obviously nursing care for all those around, but is still defined as social care?

[82] **Rhodri Glyn Thomas:** Cymerwn bwyntiau gan Karen, Jonathan a Jenny ar y mater hwn cyn i'r Gweinidog ymateb.

Rhodri Glyn Thomas: We will take points from Karen, Jonathan and Jenny on this matter before the Minister responds.

[83] **Karen Sinclair:** I just wanted to come back on a comment that you made about assessments being done automatically every 12 months. Will that cover those who pay for their own care, because they are often not attached to social workers? They are a group of people that are in residential care that are not monitored in the same way, because their care is not being paid for. It is very important that we ensure that that loophole does not exist.

[84] **Jonathan Morgan:** As we seem to be on item 3 of the Minister's report, I want to convey my concern to the Minister about the time that it takes to get an assessment. I have dealt with numerous cases, one relating to a gentleman with an advanced form of Alzheimer's, and assessment took months. The assessment only came about because the staff nurse in the hospital where he was situated—sadly because he kept falling at the home in which he was living, which was unsuitable to look after him—got the local health board and the local authority together. There were no officials within either of those organisations willing to take the lead to get the problem resolved. So there is a real concern about the time that it takes to get an assessment, and I think that we should be looking at a framework that outlines a time limit. I know that there are staffing issues, and I appreciate that it is not easy to

get the multidisciplinary team of people together to do the assessment, but it is grossly unfair on individuals and families in those circumstances who require that support but cannot get because the LHB, the local authority or a range of other professionals cannot get their act together. We should be giving people an idea of the maximum time that they should expect to wait. Otherwise, it can go on and on.

[85] The Minister mentioned in the report that a new circular has been issued with regard to some of the information that has recently come to light, and that revised guidance is being prepared. What will that mean to individuals and families?

10.20 a.m.

[86] **Jenny Randerson:** I would like to ask the Minister two questions, one of which follows on from Jonathan's. There is a need for simple, easily understood information for the families of those involved and for the patients, because, my experience in dealing with these cases is that people are totally confused by the system and are not given basic information as to the pathway that they have to follow. Very often the carers or family involved in this situation are elderly and find it difficult to get access to the information that is available. When I have looked at one or two cases, there has been such delay, confusion, and repeat visits by individuals without getting the team together and so on, that, if you look at the total cost to the public purse of procrastinating, it would have been much simpler and easier to have gone ahead and done it quickly. It is an exercise in inefficiency, and of one person not taking responsibility and passing the buck to someone else and it then being passed back again. It is not only distressing for the patient, but financially inefficient for the public sector.

[87] In relation to the NACODS judgment, there will be financial implications for LHBs as these cases come through, will there not? What line is the Minister taking on those financial implications?

[88] **Brian Gibbons:** First, the NACODS case is not the landmark case that people are suggesting. NACODS's case, as has been described, is one of a large number of cases that have been heard by Powys Local Health Board. As I said to Dai earlier, millions have already been paid out through the Powys Local Health Board mechanism. So, I do not think that there is anything distinctive about this NACODS hearing. It is a little surprising why, of all of the cases that have been through local health boards, the NACODS case is suddenly being described as a landmark case, because it is not. Having read the press reports, I am not too sure what is distinctive about it compared to the probably hundreds of other cases that have been through Powys. Between a quarter and a half of the appeals that have gone to Powys LHB have been upheld.

[89] **Jenny Randerson:** This might not be legally significant, but what is significant is that it has received a lot of publicity and I have already had one inquiry as a result of that publicity. So, it will stimulate a fresh round.

[90] **Brian Gibbons:** I accept that, but I am not clear why this individual case attracted the publicity that it did, compared with the many other hundreds that have been through Powys Local Health Board. Colleagues may remember that, when this new system was set up with the appeals to Powys Local Health Board, there were advertisements in the papers and so on. As I said, I cannot speculate as to why this particular case has achieved the publicity that it has, but, on the face of it, it is a sad situation and a bad situation for the family and the relatives of the particular individual involved; they were deprived of fair play until this case was heard. However, I am a little lost as to why this case, rather than many of the others, is being played up in this way.

[91] Every social services department should have booklets and information leaflets

available to give to people who are going to be assessed. I think that those are available; I would be shocked if they were not. Putting what are difficult legal concepts into everyday English is probably a challenge for everyone; nonetheless, there are a few basic principles underlying this. To a certain extent, the point that Dai made in relation to Alzheimer's confuses the situation. He said, if I remember it precisely, that when such a person receives nursing care, everyone can see that it is not social care. However, the whole point of continuing NHS nursing care is that the care that a person receives is of such intensity that a nurse needs to provide it, so, if a person needs that type of care, it can only be effectively delivered by a registered nurse. By definition, therefore, that should not be social care, but rather continuing NHS nursing care. The key distinction between social care and NHS care is not in the underlying reason why a person is in receipt of care, but in the nature of that care. This is where people can get confused, but if the type of care that a person needs does not require the assistance of a trained and registered professional, it is basically social care, regardless of the underlying reason why that care is being provided. As it is non-professional healthcare, the NHS, under present rules, is not expected to provide it. As I state the principle, it seems fairly clear-cut: if you do not need a healthcare professional, then the NHS will not be responsible for that particular aspect of care, even if a medical reason is creating the problem in the first instance.

[92] The assessment process is difficult, because it involves professional judgment. I think that it was Jenny who asked whether there is a simple set of benchmark criteria that you can apply. It is difficult to do that, because professional judgment is involved in a lot of this and there are no objective measurements, such as blood pressure, pulse or temperature, that you can take to come to a conclusion.

[93] The Grogan case has changed the approach significantly, because, basically, from the assessment point of view—in my lay understanding of it—the default position when you start the assessment is that you assume that the person that you are assessing will have a healthcare need and you work backwards from that, so that the primary assessment must effectively be on the assumption that the person is likely to need continuing NHS care. If the assessment demonstrates that that is not the case, a lower level of care will be provided. That is why the judge referred to the process as a 'primary health need approach'—that was one of the phrases that the judge used in the Grogan case, and my understanding of that is that your primary assumption is that there is a health need that must be addressed. If you can demonstrate through the assessment that that is not the case, then one can consider using other means of meeting the need.

[94] The process gets complicated, because, generally, the lead assessment is done by a nurse. If the nurse feels that nursing care is required, he or she is clearly in a position to make that decision. However, if it is not clear, or if it is likely that the person being assessed will need a higher level of care, a multidisciplinary assessment must be done. This is where some of the complication comes into the system—assembling the multidisciplinary team.

10.30 a.m.

[95] However, I do not think that it would be reasonable to expect that every single assessment starts on the basis of a multidisciplinary team assessment. I think that it is reasonable that someone such as a social care professional or a trained nurse should do the initial assessment and then, depending on their professional judgment, either come to a conclusion or, if it is a complex case, convene the multidisciplinary team. Because of its nature, I think that that will take a certain amount of time. I think that Jonathan is right; it would be useful to take the idea away to see whether or not this should be done within a fixed period of time. I do not have any empirical evidence to suggest what a suitable period of time is, or whether it is reasonable to bring together a multidisciplinary team in a week or two weeks. It must depend on the urgency of the case. Some cases may be complex but will not

have the same urgency as others. It would certainly be useful to take it away and ask the social services inspectorate, or whoever, for a take on it.

[96] To answer Karen's question, everyone has an assessment. Even self-funders, if they are in a care home, should be entitled to an annual assessment.

[97] **Jonathan Morgan:** To return to the point of setting a time limit, I am grateful that you will look at this to see whether it is workable. Even if, in a practical sense, you may foresee a few difficulties, it might focus the minds and the attention of those people working within social services or the local health board to get their act together. I think that that is sometimes the frustration that people, particularly families, feel—that decisions are delayed, the process gets put to one side because people are almost afraid of making a decision and committing resources. If it managed to focus the minds and the attention of those officials and individuals, I think that it would be a very successful outcome.

[98] **Karen Sinclair:** I reiterate what Jonathan has said. There is sometimes a perception, understandably, that the heel-dragging is purely a cost-cutting exercise—we might as well say it as think it, and people get very frustrated and hurt by that.

[99] **Brian Gibbons:** I do not think that there is any doubt that it is happening, even as we speak, in certain local authorities, and that the process is not as sharp and smart as it should be. I do not think that it is even a political point to say that. A number of local authorities, of all political hues, are probably dragging their feet and using administrative means to delay the assessment or the delivery of care packages.

[100] **Rhodri Glyn Thomas:** We seem to have strayed into item 3, the Minister's report. I will now take questions on 1, 2 and 4 before we take a break.

[101] **Karen Sinclair:** I have a question on item 4. The last sentence in paragraph 4.2 has to be applauded. It reads as follows:

'social services need to rebalance so that they support people earlier in order to help people retain their independence and support families so that they can care for their children whilst managing any risks.'

[102] For so long, it has been crisis intervention. The ramifications of crisis intervention are huge, because so much emotional damage is often being done. There will be a problem in that; while we move to earlier intervention, which is obviously better, you will still have another service that has to be run in tandem, which is the crisis intervention service. Therefore, what safeguards will there be for local authorities so that they can run both of those services, because there is a huge cost implication to that transition period?

[103] **Rhodri Glyn Thomas:** I will take questions from Dai Lloyd and Jenny on 1, 2 or 4.

[104] **David Lloyd:** On item 4, I am grateful for the update on the social services strategy paper. In terms of committee scrutiny, will the committee discuss this strategy paper in some depth, because what we have here rather lacks detail in terms of progress? Is there a suggestion somewhere that we, as a committee, can discuss this matter in detail? Therefore, in terms of scrutiny of the process can we can have more meaningful scrutiny of it, rather than it just being a couple of paragraphs here?

[105] **Rhodri Glyn Thomas:** If there is a genuine feeling among committee members that they would like that to happen, and they seem to be nodding, we will look at the possibilities. It will not be until the new year, but we will certainly look at it at that point.

[106] **Jenny Randerson:** I wanted to express my disappointment with this document. I would not disagree with the wording, but I am disappointed when I look at it as a parallel document to 'Designed for Life'. In relation to 'Designed for Life' everyone said, 'Very good vision; it poses some difficult questions about reorganising resources and it is going to be tricky', but we could see in much more detail how tricky it was going to be. This document is at a much higher level, because it is really a vision statement. We would all sign up to the point that Karen made that early intervention is a good idea as opposed to waiting until crisis point. However, it seems that this document—I realise that it is a strategic document—does not even go down to the level of detail that 'Designed for Life' did in terms of how we are going to reorganise things to achieve the aims. I found it to be disappointing in that respect. We have a long way to go to work through it and see how we can achieve that vision. For that reason, I would strongly recommend that we look at the document in some significant detail, because I think that we could all pose some difficult questions that really need to be taken on board.

[107] **Jonathan Morgan:** I agree with Dai and Jenny that there is a lot in here that people will sign up to. If you maintain that social services should remain a unified and integral part of local government, it is local government that has to sign up to it. When you read the recommendations and some of the outcomes in the Care Standards Inspectorate for Wales's report, you will see that we are a long way off achieving what you have outlined in the strategy paper. We can sign up to it, but, sadly, the current reality is very different to the aspiration.

[108] **Brian Gibbons:** The document needs to be seen as a White Paper, or even a Green Paper, rather than as a document that has definitive Welsh Assembly Government ownership at the moment. It has not been sent out for implementation; it has been sent out as a cross between a Green Paper and a White Paper. It indicates some of the semi-formed views that we have taken, but it does not include rigid detail. 'Designed for Life' was issued at the end of a long protracted process in the wake of Wanless and was the final distilled outcome of that. I do not think that 'Fulfilled Lives, Supportive Communities' is at that end stage yet. The response to 'Fulfilled Lives, Supportive Communities' possibly will have that status, but I do not think that the document at this stage should be seen as a final, formed, distilled version. There is plenty of scope for rejigging the emphasis in the plan.

[109] If you look at the foreword to the paper, you will see that that option is there. We have said that certain conclusions have been reached, but, before those conclusions were reached, certain considerations were taken into account. While that is the Welsh Assembly Government's take on things, the reason that we have put them in the foreword is that, if people have a substantially different point of view, putting them in the foreword will stimulate the argument and will show that the position is not totally closed down, even though we felt that this was the way that we should go. We said that we felt that local government was the best home for social services, but, in stating that, we were saying to people that, if they felt that that was not the correct conclusion, they should rise to the challenge.

10.40 a.m.

[110] We asked whether the boundaries of social care are accurately defined. In general, we thought that they were within the challenges outlined in the document. However, if people thought otherwise, then the fact that we mentioned it in the foreword was an invitation to them to take issue with that. On the nature of the workforce, is the workforce and the skill-base mix, which we regard as being conventionally within social care, right? In the foreword, we suggest that it was possibly not—we needed to think whether there should be a more systematic use of trained, skilled social-work assistants, and so on. However, again, we did not prejudge that issue, and we invited a response from people. Therefore, people will hopefully take that challenge on board. Some of the points that Jenny raised will, hopefully,

be dealt with, because the foreword is there, inviting people to take other perspectives if they so wish.

[111] I do not know whether Jenny has had an opportunity to look at the Scottish document—probably not. The Scottish Executive has also produced a consultation document, covering more or less the same territory. It surprised me when I read it how similar they were, and how they identified the significant challenges in social care in Scotland; seeing that, it would be fairer to say that the overall perspective that Scotland and Wales are taking to all these issues is probably more similar than what takes place between England and Wales. It was reassuring to me that the Scottish perspective so closely mirrored what we were doing in Wales, and it started from an independent point of view. The document, 'Fulfilled Lives, Supportive Communities', was written and was out in the community for consultation before I even saw the Scottish document. It was a welcome reassurance, because they were looking at the same problems.

[112] In many ways, Karen's point is at the crux of it. We need universal services and entitlements for all young people. However, there is a group of young people who are vulnerable, or at risk, and they need a series of generic, collective, targeted services to try to stop their situation deteriorating. That is not to take away from the need for specialist intervention for children who have specific needs. However, I suspect that that will demand a redesign of the philosophy of social work and social care in Wales, and even the nature of the workforce. I do not suppose that we will go back to community workers, as they were in the 1970s and the early 1980s, but some sort of new type of community worker will possibly come out of this, which we do not have at present.

[113] **Rhodri Glyn Thomas:** It may be appropriate, therefore, that we look at this paper when the consultations come to an end and the responses have come in. That will give us a fuller picture of the situation, and we will be more informed to deal with it.

[114] We will break now for 15 minutes, and return at 11 a.m. for the rest of the Minister's report.

Gohiriwyd y cyfarfod rhwng 10.43 a.m. a 10.59 a.m.
The meeting adjourned between 10.43 a.m. and 10.59 a.m.

[115] **Rhodri Glyn Thomas:** Er ei fod ychydig yn gynt nag 11a.m., fe ddechreuwn ni oherwydd yn ogystal â gweddill adroddiad y Gweinidog, mae gennym hefyd adroddiad Arolygiaeth Safonau Gofal Cymru i'w drafod a hoffwn ddiogelu digon o amser i wneud hynny a gorffen erbyn 12.30 p.m. os gallwn. Felly, ar eitemau 5 i 8 yn adroddiad y Gweinidog, Dai Lloyd sydd am ofyn y cwestiwn nesaf.

Rhodri Glyn Thomas: Despite the fact that it is a little earlier than 11a.m., we will begin because in addition to the rest of the Minister's report, we have a report from the Care Standards Inspectorate for Wales to discuss, and I would like to safeguard enough time to do that and to finish by 12.30 p.m. if we can. Therefore, on items 5 to 8 in the Minister's report, Dai Lloyd wants to ask the next question.

[116] **David Lloyd:** On item 5, the delay in issuing the National Health Service (Pharmaceutical Services) Regulations 2006, the ministerial directions for community pharmacies were due on 1 October, which would allow the uplift of medicines use reviews, conducted by community pharmacies, to rise from £200 to £400 a year. Clearly, there are funding implications in doing more medicines use reviews, but, as I understand it, this uplift has happened in England. I also understand that the uplift was due to happen in Wales from 1 October, yet nothing appears to be happening. Could the Minister clarify the situation?

[117] **Rhodri Glyn Thomas:** Jonathan, do you also want to comment on item 5?

[118] **Jonathan Morgan:** No, not on this.

[119] **Brian Gibbons:** We would like to get these regulations in place as quickly as possible. Indeed, if other parties were willing to work with us to co-operate on facilitating any accelerated legislative process, we would be prepared to work to that process. We should be able to get them in place by January, but if there were willingness by all parties, we could certainly try to bring it forward more quickly.

[120] **Rhodri Glyn Thomas:** Can you give us an insight into who these other parties might be?

[121] **Brian Gibbons:** It might be the Welsh Conservatives, the Welsh Liberal Democrats and Plaid Cymru—or Plaid, as I think it is called now.

[122] **Rhodri Glyn Thomas:** Right, but I am still not aware of the problem, in terms of the delay.

[123] **Brian Gibbons:** Clearly, we have to go through a full standard procedure in the Assembly and if we go through that, it would probably take us until January for the regulations to be introduced, because that is the timescale for all of these things. If we went through some of the more accelerated legislative options open to us, without having to go through the full standard procedure, we could get the regulations in place earlier.

[124] **Rhodri Glyn Thomas:** In that case, it is a matter for the Business Committee, and the Chair of that committee needs to be made aware of that fact.

[125] **David Lloyd:** On this point, Chair, it is not—[*Inaudible.*]—cross-party agreements. Surely it could go just through the executive procedure, so it is a matter for the Business Committee.

[126] **Jonathan Morgan:** I agree. If there is a delay in the regulations—and, often it is not the fault of the Assembly that those regulations are being delayed in coming forward, but the fault of others—I do not think that we should be circumventing the Assembly's procedures purely because of mistakes made elsewhere. I accept that if regulations are not controversial, we should do what we can to get them through as quickly as possible, but we cannot say, 'Let us chuck scrutiny out of the window', simply because the regulations have been delayed by other people.

[127] **Rhodri Glyn Thomas:** I will inform the Chair of the Business Committee, when she returns, that members of this committee have expressed the view that, unless there are contentious issues, we want that process to go through as quickly as possible.

[128] **Brian Gibbons:** I do not want to prejudge this, but I cannot believe that there is a problem, because the process is precisely the same, except that the threshold has increased from £200 to £400. As I understand that, in practice, at the absolute maximum only some 10 per cent of pharmacists are in this position. I would suspect that there are actually a good few less. It does affect a vast body of pharmacists, but for those who have been innovative and positive in working the new pharmacy contract, we must encourage and facilitate them in the good, innovative work that they do, rather than hold them back.

[129] **Rhodri Glyn Thomas:** Now that Jenny has returned, I can tell her that we are discussing the delays in the pharmacy regulations and, wearing your hat as Chair of the Business Committee, members of this committee have made the point that unless there are contentious issues with these regulations, it would be useful if they could go through the

process as quickly as possible. When they come before your committee, perhaps you could ensure that that happens.

[130] **Jenny Randerson:** If the committee has not identified them for scrutiny, or has identified them for scrutiny, but expressed itself to be totally content with them, I am sure that we would be happy to facilitate that.

[131] **Rhodri Glyn Thomas:** That completes that point. We move onto point 6 of the Minister's report.

[132] **Lynne Neagle:** I want to ask about the Book Prescription Wales scheme. The Minister's report says that the scheme has been independently evaluated. Is the coverage of the scheme fairly universal in Wales? What is being done to promote it, so that it is available to all patients who need it?

[133] **Brian Gibbons:** It is fairly universal. As you can see, more than 300 libraries are already involved. The way in which it is rolled out in each part of Wales is not precisely the same. In some places, the librarians are more proactive in directing people towards the books that are available. In other cases, the books are not so obvious, and people have to inquire where they are. There is a bit of a mixed picture with regard to how the scheme is promoted. That is also the case with regard to the way in which professionals—and GPs in particular, but not exclusively—promote the scheme.

[134] Overall, the evaluation shows that this has been an outstanding success. Indeed, many regions of England are looking at what we are doing in this area, and I am led to believe that even places outside the United Kingdom are interested in this scheme and in spreading it abroad. Before too long, the scheme could do with a re-launch or some reinvigoration. The scheme will work if new people coming into the system are made aware of it again. Perhaps it would be worthwhile if GPs were re-alerted to the possibilities and options of the scheme, but, overall, we are more than pleased with how it is going.

[135] **Rhodri Glyn Thomas:** Moving on to item 8 of the Minister's report, Jonathan and Karen wish to speak.

[136] **Jonathan Morgan:** First, on the funding for the next phase of the children's hospital, you said that the Government has already contributed £4.9 million, which was spent on the first phase. What proportion of that sum was spent at the Heath hospital, and what proportion was spent on Llandough Hospital? I suspect that not all of the money was spent at the Heath hospital site, because certain services were rearranged and transferred to Llandough Hospital. I wonder what the split is. I suspect that a portion in the range of £1 million to £2 million was spent at Llandough Hospital, but can you confirm that?

[137] You said that the outline case is in its development stage, that you are waiting for that, and that you expect something towards the end of this calendar year. Do you expect to be able to make a decision before the end of this financial year as to the allocation of resources? What sort of timetable do you anticipate? You have already said that the outline case will be ready towards the end of this year. That is the first stage. Therefore, given your experience and that of your department, how long do you think it will be, on average—and bearing in mind all the other business cases that you have had in the past umpteen years—before we can actually see resources being allocated to this? I, for one, do not expect you to be in a position to do anything before the election next year. If that is the case, it is obviously a very sad position for us to be in, because it would have been a nice note on which the Assembly could have ended its second term. So, I would like more information on what you anticipate the timetable will be.

[138] Have you met with the Cardiff and Vale NHS Trust and with other partners to examine a timetable and how their work is progressing? You have officials who work closely with NHS trusts, and I imagine that they should be in a position to provide as much assistance as possible in working up the outline case that will come to you.

[139] Do you agree with the First Minister's public statement that the Noah's Ark appeal was merely making noises about this problem and the lack of commitment of funds simply because he felt that it did not have another role to play? He was quite disparaging in his remarks to local newspapers about the role of the Noah's Ark appeal, and the fact that it was sounding off simply because it felt that it had no role to play beyond the first stage of the children's hospital development. I hope that there is goodwill in the Assembly Government for what the Noah's Ark appeal has contributed and achieved, as that does not seem to be case, judging from the First Minister's remarks.

11.10 a.m.

[140] **Karen Sinclair:** I want to comment on paragraph 8.1 in which you talk about the children's hospital for Wales. As I have said many times, it is a children's hospital for south Wales, and it does not impact on north Wales at all. It is important that it is not called the children's hospital for Wales for those reasons. How many children outside Cardiff and the Vale use the service?

[141] **Rhodri Glyn Thomas:** I would just make the point that a number of institutions in Cardiff are national institutions, although, geographically, they are a great distance away from north Wales.

[142] **Jenny Randerson:** On the current use of the service being more limited, it is because we do not have the agreements that we should have to ensure that it provides a service for the whole of south and mid Wales. I understand Karen's point about accessibility from north Wales, but I do not think that that is a reason for not calling it the children's hospital for Wales—until we also have a children's hospital in north Wales, of course, when it might be time to reconsider the title.

[143] I reiterate Jonathan's point about how counterproductive the First Minister's attitude was in public to the significant contribution of the Noah's Ark appeal. In case the Minister is not aware, it is still raising money, and it has an immediate target of raising another £600,000 to provide additional facilities. We have to be careful that we do not denigrate charitable and voluntary sector organisations and their contribution to the national health service. We ought to be doing far more to encourage them, because we have to recognise that the potential health demands of the nation outstrip the financial resources of the NHS both as it stands and, probably, in the future.

[144] Minister, I want to ask about the funding of the revenue consequences. When I asked the first question to the First Minister on this in Plenary, he talked about the complexity of the process of getting this funded. Minister, have your officials been involved in co-ordinating between the various organisations that should be committing to funding the revenue? If not, they should be. You could make a case for having different commissioners and so on, and we all accept local accountability, but, when you commission a complex package like this, there is a role for Government officials in ensuring that people co-operate to do that. My information is that the trust put in a bid some considerable time ago, which was withdrawn, and it has taken a long time to change that and to get around to resubmitting it. Why has there been such a long time delay?

[145] **Brian Gibbons:** Thank you. Jonathan, will you accept a note, which we can copy to all committee members? My understanding is that the overwhelming majority of the money

was spent at the Health hospital as part of the build, but I do not know whether that is the case. A lot of that happened before my time, but I assumed that, and no-one gave me any information to suggest the contrary. We will get a note out to you and let committee members know if that is not the case.

[146] In terms of what we are doing to facilitate this, first of all, it is up to Cardiff and the Vale as the main organisation leading on this. It has to work with Health Commission Wales—in the main, but not exclusively—and it has to work with its local health boards, because in Cardiff and the Vale in particular there is a local district general hospital element to this business. The trust also has to work with other trusts and colleagues to build up the care pathways. We in the Assembly Government try to facilitate this mainly through our regional office in south-east Wales, which is the main organisation trying to broker the sort of deal that you suggested, and I think that the south-east Wales regional office is fairly active in trying to facilitate that.

[147] In relation to the First Minister's comment, I do not know where it was made, but I know from direct personal experience of the First Minister's approach—I have sat in on many meetings, and we have had many meetings, about the next phase of the children's hospital in Cardiff—that the First Minister is very committed to the next phase, and it would be 110 per cent incorrect to suggest anything else. I know that for a fact. Not only that, his commitment to working with the voluntary sector on this particular project is 110 per cent. I do not know what form of words was used, but then I am not responsible for the form of words used or how the matter was reported. I just know from personal experience of dealing with the First Minister on this particular issue, and from meeting Noah's Ark and other people in the voluntary sector who are interested in trying to move this project forward, that the First Minister has a very strong personal commitment to this project as a whole, and to fully developing partnerships with the voluntary sector to facilitate this development as well. However it transpired that a different impression was given, my direct experience from hours in personal meetings with the First Minister and people from the voluntary sector on this project suggests to me absolutely the contrary. Hopefully, that clarifies that particular issue.

[148] Karen's question is very much at the crux of the matter, and Dai Lloyd will probably remember certain articles in the *South Wales Evening Post* that suggested that some paediatricians do not regard the children's hospital in Cardiff as a big priority. Indeed, even considering the point that Karen makes, they would argue that the children's hospital in Cardiff is not a children's hospital for south Wales, even; they would say that it is a much more narrowly-focused hospital than that. This is one of the problems that we have in developing commissioning pathways for a children's hospital because, if it is going to be a children's hospital for south Wales, then, clearly, all in south Wales have to sign up to delivering this children's hospital. Karen has pointed out some of the problems that we have in calling it the Children's Hospital for Wales, when it probably does not reach beyond Powys. If people are saying that it is not even a hospital for south Wales, but only a children's hospital for south-east Wales, then this makes brokering commissioning support for this project more difficult.

11.20 a.m.

[149] However, to try to answer Karen's question, the information that I have had in terms of the children who are using the children's hospital in Cardiff from local health board areas west of Bridgend is that around 415 children have come from Bridgend, Swansea, Neath Port Talbot, Carmarthenshire, Pembroke and Ceredigion as in-patients and over 800 have come from those areas as out-patients. Over 700 in-patients and almost 600 out-patients have come from Newport, Monmouthshire and Blaenau Gwent, almost 200 have come from Rhondda Cynon Taf and Powys, and just under 350 have come from Rhondda Cynon Taf and Powys as out-patients. So, there seems to be a reasonable flow of patients to the service. However, if we

are going to be able to develop a children's centre for south Wales, all of south Wales has to have a sense of ownership of that children's hospital, and local commissioners and clinicians who would be using that hospital as a tertiary service have to sign up. If we do not have that sign-up right across south Wales and a sense of ownership of the hospital and using it as a tertiary centre, we could end up spending £30 million or £40 million building a white elephant that is nothing more than a glorified district general hospital for Cardiff.

[150] **Jonathan Morgan:** I would like to say how much I agree with the Minister on that final point. Unless we get this absolutely right and people understand the consequences, in that a children's hospital for Wales will mean that certain services will be shifted around and located at this new centre, in order to make it a proper centre of excellence for paediatric services, people will have completely wasted their time, money and effort in putting together the first phase of this ambitious project. You, as Minister, and the First Minister, need to show a great deal of leadership and ministerial direction in saying that you as an Assembly Government feel that this is the right option for Wales. I know that there are partners and commissioners who have to take decisions, but I really think that you ought to set some direction in stating that it is the Assembly Government's policy that this should become a centre of excellence for children's services so that the commissioners really know what your direction of travel is.

[151] **Rhodri Glyn Thomas:** Jenny Randerson will make the final point on this.

[152] **Jenny Randerson:** That was the point that I was making when I said that I would expect Government officials to be involved in brokering the complex package. I was rather disappointed, Minister, that you said that this was being done at regional-office level. I would have hoped that it would have been dealt with at a higher level. There should have been a ministerial steer on this because, potentially, for the children of Wales, this is of immense benefit and it should not be undermined by parochialism at any level, by any person. We should be thinking about the best equipment and the best service.

[153] **Brian Gibbons:** To respond to that, Dai and Rhodri Glyn, as chair, will know of the difficulties in terms of getting sign-up for this and of the difficulties for me as Minister to dictate commissioning priorities for the health communities—unless you are suggesting that, by ministerial diktat, we should dictate what local commissioning priorities and directions should be. We are doing as much as possible to broker it. The indicative money is in the budget, which is the ultimate test. We, including the First Minister, are actively engaged with the regional office on a fairly regular basis. However, I cannot—unless you are suggesting that I do this—impose ministerial diktat on every health community and walk all over local health organisations' commissioning decisions. If that is your view, you should come out and say that. We are trying to facilitate and broker progress, but we need sign-up across south Wales to deliver a children's hospital for Wales/south Wales.

[154] **Rhodri Glyn Thomas:** We do not have time to go into a detailed discussion about commissioning services, but the points have been raised and the Minister has responded. We need to move on to items 9 to 12.

[155] **David Lloyd:** On item 9, car parking charges, the issue has doubtless been aired in this committee before, but it continues to be an area of huge concern and I regard it as a tax on illness. There is a lack of detail in the report, so would it be possible to have a paper at some point to detail exactly how much money is raised in this way across Wales? I realise that comments have been made about it being the responsibility of each trust, but in terms of scrutiny of the process for this committee, it would be useful to have a handle on exactly how many zillions are raised in this way every year, and also an overview of the breakdown trust by trust. It would also be useful to have some idea of the actual charges levied to the public on a trust by trust basis. I do not expect such detailed answers from the Minister now, but a

paper at some point would be useful.

[156] I also have a question on item 12, but I will leave that for now.

[157] **Lynne Neagle:** I was also going to ask for a more detailed breakdown of what the charges are in different trust areas, so that we can make a comparison. It seems to me that as well as charges being problematic for people that have to use hospitals a lot of the time—people who are very sick—we should also look at the issue of disparities in different parts of Wales. Will the Minister consider linking that information to other hidden costs faced by patients, such as telephone charges in hospitals, and provide an update on charges in different trusts for those items, and on the progress with regard to the new guidance that he has issued to trusts on mobile phone use?

[158] **Karen Sinclair:** I asked for this item to be included, and I feel strongly that a full report on the amount of money that is being made by each trust would be interesting and illuminating. It has been brought to my attention that visiting is quite expensive for families of elderly patients, in particular, who need that support at their bedside. The location of the hospital sometimes makes it more difficult. It is okay if there is a bus stop outside the hospital, but if not, you are forced into coming in a car and paying. The idea of being inside a hospital and thinking that you must go out and get another parking ticket after two hours is quite intolerable for people. So, I implore Brian to look at this issue, because it is undoubtedly causing problems.

[159] **Brian Gibbons:** We will provide a breakdown. The average income derived from charges is about £4.1 million to £4.2 million a year; I have reported that before to Plenary or the committee. We will break down the figure by trust. One of the difficulties that we have is if that income is not available to the trust through charges, it must be made up in some other way. We have the budget that we have, so there will be an element of choice and deciding on the priorities in all of this.

[160] In relation to the telephones, we will see whether we can get that information. Ann tells me that it might be quite difficult to do that, because we have said in Wales that, in contrast to England, whether or not a trust puts in a telephone system is a discretionary matter, so it is entirely up to the trusts whether or not to put in a system. Equally, it is a discretionary matter for patients whether they use the telephone system or not. My understanding is that virtually all hospitals continue to provide the traditional landline coin-operated telephone. The guidance from the Department of Health, rather than the Assembly, on mobile phone use, means that people in most clinical areas should be able to use their mobile phones. So, people should not be required to resort to using these commercial bedside consoles, which can be relatively expensive. However, as I said, they are not mandatory either for the patient to use or for the trust to install. I often get the impression that they are not heavily used by patients, who use the slot phones, pay phones and so on. However, if we can get the information without it costing a lot, we will do that. These are discretionary matters, so there may be issues of commercial confidentiality that we need to consider. If we can sort out the technicalities and if, proportionally, it will not be very demanding, we will try to get that.

11.30 a.m.

[161] **Rhodri Glyn Thomas:** Karen, do you want to come back quickly on this?

[162] **Karen Sinclair:** You are talking about the breakdown of money raised by the trusts on car parking charges. As far as I was concerned, the argument initially by individual trusts for bringing this in was that it was a traffic management system; it was not introduced as a revenue stream. We must remember that.

[163] **Brian Gibbons:** My understanding is that this is not a profitable business for most trusts. The vast majority of the money that is generated through charges is precisely used as Karen said. Some trusts may be making more than that on the margins, but in the generality, my understanding is that the overwhelming bulk of this money is for car parking and traffic management, rather than income generation. I do not doubt that there may be some money on the margins for income generation, in some cases, but I do not think that it is a big earner.

[164] **Rhodri Glyn Thomas:** Finally, I will take questions from Lynne Neagle on item 11 and from Dai Lloyd and Jenny Randerson on item 12.

[165] **Lynne Neagle:** I thank the Minister for the update that he has provided on waiting times for bone-marrow transplants, but it does not actually give the waiting times. There is useful information on steps to improve capacity and so on, but the concerns that I raised initially on this were in respect of a constituent who was facing a lengthy wait for a bone-marrow transplant, so it would be helpful to know what the current situation is in relation to waiting times. I was also interested to read that the trust is piloting the use of hotel facilities for bone-marrow transplant patients. I understand that hotel facilities have been used effectively for some procedures in England, but I was a bit surprised that they were being used in this instance; my understanding was that stringent measures had to be in place to stop people who have had bone-marrow transplants from coming into contact with any illnesses and so on. I would be interested in more detail on that. Finally, the Minister had indicated that, in relation to this problem, he would explore whether there was a potential to use capacity in England or elsewhere in the UK for these procedures.

[166] **David Lloyd:** My question is on the work of the Wales Neuromuscular Network, as I have met its representatives a couple of times over the last few months; muscular dystrophies continue, and some 200 patients in Wales have Duchenne muscular dystrophy. There are exciting, innovative developments as regards treatments now on the horizon. These developments are taking place in other countries—such as the Irish Republic—such as gene-skipping therapy, which can do something about Duchenne muscular dystrophy. This work will be hampered by the potential disappearance of the Wales Neuromuscular Network, if its funding situation is imperilled.

[167] There are a lot of words in this solitary paragraph on this important issue, but I am not clear as regards what will happen on funding. Will any funding be contemplated at any stage or will the Wales Neuromuscular Network have to soldier on using voluntary contributions gained via the muscular dystrophy campaign and nothing else? That would be a great shame in terms of neurology and the NHS follow-up in the University Hospital of Wales and other out-patient clinics. It is an integral part of the NHS, and forgetting about the Wales Neuromuscular Network because funding priorities are elsewhere would be a huge shame, because providing supportive services, and potentially developing exciting treatment services, for people with muscular dystrophies of a variety of sorts should be an integral part of NHS services.

[168] **Jenny Randerson:** It was my understanding—the Minister will know that I have asked him many questions about this—that the funding for this network came to an end at the end of July. If it is still soldiering on, it is probably on a much-reduced basis. There is a danger that the expertise that has been built up will have disappeared by the time that we get to decisions for next year. I have said before that it is counterproductive to spend some money, build something up and then allow it to disintegrate. You are doing work on networks, are you not, Minister, that will have an impact on the future of this network and others?

[169] If it is a network, I want to identify why the Cardiff and Vale NHS Trust's interest in

it is allowed to be the deciding factor when, almost by definition, a network should go well beyond a local trust. It should not be down to a local trust to support a network.

[170] **Brian Gibbons:** To deal with the neuromuscular network, the representative of which I have also met, the network is not, in this sense, the same as when we talk about cancer networks or cardiac networks and so forth. The neuromuscular network is more of a voluntary sector organisation than a network that is integrated into the clinical set up of the NHS in Wales. Therefore, even though both are called networks, it would probably be more accurate to call the neuromuscular network a voluntary sector organisation rather than something that is integral to the NHS. Cancer and cardiac networks, for example, do not operate on the same basis.

[171] It is very much Cardiff-based because its initial funding came for muscular dystrophy, I think, channelled through Cardiff University; it was never channelled through the NHS. It was when university funding for what was, effectively, a voluntary organisation, or a voluntary structure, ended that it came looking for support from the NHS. Clearly, the NHS was not in a position to support the network as a voluntary sector organisation any more than it is able to support many other very worthwhile voluntary organisations, such as Tenovus.

[172] Having said that, a number of issues that concerned the network are being taken forward. Hopefully, we will be launching the epilepsy and neurological commissioning and service development frameworks within the next few months. I understand that the Wales Office for Research and Development has a number of research streams—I do not know whether the chief medical officer may be able to give more detail—that very much link into what the neuromuscular network was interested in. I understand that the network itself still continues to operate, although I am not really up to date in terms of its internal workings and how vigorous, vibrant and sustainable it is. However, I think that it does continue. Many of the key issues that it wishes to move forward are being moved forward in any event.

11.40 a.m.

[173] Moving back to the point that Lynne made, clearly, in any transplant situation, one of the rate-limiting factors is always the availability of donors. It is difficult to give a definitive figure for waiting times because, if appropriate donors are not around, you cannot do a transplant. Having said that, there is an acknowledgment that Cardiff and Vale NHS Trust and UHW are not operating as well as we would like and, in fairness to them, as they would like. Some patients have gone to Bristol for transplants in the past. It is one of the areas that Health Commission Wales is working on with Cardiff and Vale NHS Trust to try to find a way to improve access. By the nature of the speciality, it is a difficult issue, but I do not think that any of us are happy or think that it is working as well as it should. We hope that we will see improvements as time goes on.

[174] On the use of hotels, there are hotel facilities in a number of places, including Bro Morgannwg, but just the context of hotel facilities—

[175] **Dr Jewell:** I am not sure about that.

[176] **Brian Gibbons:** I cannot believe that hotel accommodation would be for people who have had a transplant. I think that Lynne is right in that sense. Whether or not it would be for either people waiting to donate or marrow or whether it would be for—

[177] **Dr Jewell:** It would not be for the ones who received a transplant.

[178] **Brian Gibbons:** It would not be for the recipients because, you are quite right, you would need specialised facilities to protect them from infection and so forth.

[179] **Rhodri Glyn Thomas:** Yr ydym wedi cael cyfle i edrych ar bob eitem yn yr adroddiad—yr oedd ychydig mwy o amser ar gael. Ynglŷn â'r pwynt olaf ar ystafelloedd mewn gwestai, efallai y gall y Gweinidog baratoi nodyn yn egluro pa ddefnydd yn union sy'n cael ei wneud ohonynt. Sicrhawn fod y nodyn hwnnw yn cael ei rannu gydag aelodau'r pwyllgor.

Rhodri Glyn Thomas: We have had an opportunity to look at every item in the report—there was a little more time available. On the last point on hotel rooms, perhaps the Minister could prepare a note explaining exactly what use is made of them. We will then ensure that that note is circulated to committee members.

11.41 a.m.

Rhestr o Is-ddeddfwriaeth
Schedule of Secondary Legislation

[180] **Rhodri Glyn Thomas:** Mae angen ichi nodi unrhyw ddeddfwriaeth yr ydych am i ni ei hystyried. Mae'r newidiadau wedi eu cysgodi yn y papurau ac os ydych am ailedrych ar rai o'r rhain, gallwn geisio gwneud hynny, ond mae amser yn brin. Bydd rhai o'r materion deddfwriaethol yn mynd ymlaen i'r trydydd Cynulliad a byddwn yn cyflwyno'r rheini mewn adroddiad trosglwyddo i'r Cynulliad newydd ar ôl yr etholiadau.

Rhodri Glyn Thomas: You need to note any legislation that you wish for us to consider. The changes are shaded in the papers and if you want to revisit some of these, we can try to do that, but time is short. Some of the legislative matters will be taken forward to the third Assembly and we will present those in a transfer report to the new Assembly, after the elections.

[181] **Jenny Randerson:** Under new legislation, the National Health Service Wales The Pharmaceutical Services (Advanced and Enhanced Services) (Wales) (Amendment) Directions—the last item, on the last page—is something that we have been awaiting eagerly and I believe that the committee ought to look at it, because it is very important. I gather that it is going to go through next month, which would be helpful.

[182] **Brian Gibbons:** This concerns what we spoke about earlier in terms of trying to get it through the Business Committee quickly.

[183] **Jenny Randerson:** Yes, but we ought to look at it and check it. Does that not just mean that you would not have a Plenary debate on it? The role of the Business Committee, Chair, is to see whether we need to spend time on legislation in a Plenary debate; not spending time on a Plenary debate means that you can fit in the item earlier in the agenda, because you only need 1 minute to vote on it. That does not mean that the committee should not look at the legislation to check that it is alright. This may arise because I missed the first bit of the discussion.

[184] **Rhodri Glyn Thomas:** I understand the role of the committee; I have attended the Business Committee on a number of occasions. The feeling here was that there was a need to ensure that this process goes through as quickly as possible. That does not preclude us, of course, from looking at the legislation in committee, because that would not necessarily slow the process down. If you feel that you want us to look at it, we can do that under legislation.

[185] **Jenny Randerson:** Can it not be done next time?

[186] **Rhodri Glyn Thomas:** If you want to quickly look at it then—

[187] **Jenny Randerson:** Could it be slotted in next time, so that it would not delay it?

[188] **Jonathan Morgan:** The target date is November, is it not?

[189] **Rhodri Glyn Thomas:** There is a protocol, which we would have to abandon; however, if committee members are happy for that to happen—

[190] **Jenny Randerson:** Do you want to circulate it out of committee, Minister?

[191] **Rhodri Glyn Thomas:** The view is that it is not a contentious piece of legislation, so I am happy to waive the protocol. If you feel that you want to look at it, we will look at it quickly at the next committee meeting.

[192] **Jenny Randerson:** It could be circulated out of committee, which would not delay it by a single day.

[193] **Brian Gibbons:** We would be happy to do that.

[194] **Jenny Randerson:** Then it would just be by default that, if we all thought that the legislation was fine, it would go ahead.

[195] **Rhodri Glyn Thomas:** With your agreement, we will do that and, hopefully, that will not slow down the process of implementing that legislation. I see that there is nothing else on legislation.

11.45 a.m.

Adroddiad Arolygiaeth Safonau Gofal Cymru
Report of the Care Standards Inspectorate for Wales

[196] **Rhodri Glyn Thomas:** Mae Rob Pickford a Natalie Cooper yma i'n cynorthwyo gyda'r eitem hon. Mae Rob am wneud rhai sylwadau agoriadol, a chydymdeimlwn ag ef, gan fod ganddo anhwylder ar ei lais, felly gobeithio y cymerwch hynny i ystyriaeth wrth ofyn cwestiynau a gwneud sylwadau.

Rhodri Glyn Thomas: Rob Pickford and Natalie Cooper are here to assist us with this item. Rob will make some opening remarks, and we must sympathise with him, as he has an illness affecting his voice. I hope that you will take that into consideration when asking questions and making comments.

[197] **Mr Pickford:** Thank you, Chair. It probably leaves me in the position of doing a passable, if somewhat unlikely, impersonation of Marlene Dietrich. If you can live with that, we should get through it. If I completely lose my voice, Natalie will be more than delighted to answer questions. She may question me later as to why I lost my voice on a particular question, but that will be a matter for her and me. [*Laughter.*]

[198] I have just a few words of introduction, because most of this morning is about you asking me questions rather than the other way around. Producing this annual report is a statutory responsibility. It has two basic functions: to report on what we have found in the business of regulation, and also there is an accountability element to it, in terms of how we have gone about that, and what your views are on that process.

[199] On what we have found, it is important to stress, as we have tried to do at the beginning of the report, that there are many good-quality social care services around Wales.

As Members, you know that, because you see them daily, and the 70,000-odd staff who deliver those services work enormously hard to deliver them. You will also have seen that there is evidence of improvement in a number of those services, which is good news. However, you will also see that there are some challenges, particularly around residential services for adults and children—I am sure that that will form the basis of some discussion as we go on today.

[200] The report also identifies quite a radical change in how regulation works in Wales, which we have badged as the reform of regulation in Wales, to move it to being a more proportionate and service-user-focused activity. That comes down to recognising that, where there is clear evidence that progress is being made, it is reasonable for the provider to see less of the regulator and the inspector. You will see in this report that that is very much the case in early years services, with, this year, approximately 1,000 fewer inspections being conducted around Wales as a result. The opposite of that also applies—where there are concerns, I suspect that your expectation, and certainly mine, is that those services will receive greater attention from us, rather than less. That has to be managed within what is, in anyone's book, a challenging resource environment for us all. Spending more time in some places means spending less time in others.

[201] The report also identifies—and I say this with some hesitation, having devoted five years of my working life to this—that regulation alone is not the answer to these issues. The report suggests that there needs to be a debate and a rethinking about the balance between the role of the provider, the commissioner, and the regulator in securing improvement. The report mentions that as an issue. I suspect that, again, that may form the basis of discussion here, particularly in the context of 'Fulfilled Lives, Supportive Communities', as it gives us an opportunity to look at where social care and social services across Wales need to be going.

[202] That was a very brief overview. I suspect that the best use of our time is for me to seek to respond to your questions.

[203] **Rhodri Glyn Thomas:** Diolch, Rob. Yr wyf yn hapus i dderbyn cwestiynau neu sylwadau am unrhyw ran o'r adroddiad.

Rhodri Glyn Thomas: Thank you, Rob. I am happy to take questions or comments on any part of the report.

[204] **Jenny Randerson:** Inspection is clearly not the answer, is it, as things have got worse in so many areas? One thing that deeply concerns me is that we read loads of reports and, in most cases, you see maybe an uneven pattern, but a definite pattern of improvement that goes with inspection and modern regulation and so on.

11.50 a.m.

[205] We seem to have had a plethora of regulations in this field in recent years. We certainly now have a good inspection regime, but things have got worse. I am particularly concerned about the picture in children's homes. We have said for years that we are failing our most vulnerable children, and we are failing them even more now than we were to begin with. You say, in your report, that some of the poor quality is the result of different services failing to join up. We hear that theme all the time and you have also just said that inspection alone is not the answer. Can you give us a positive steer on what needs to be done to ensure that there is some improvement? This does not relate to children's homes only; it goes across adult and fostering services and so on.

[206] **Mr Pickford:** Through the regulations that you have made, the regulations and the regulatory framework, and not the Care Standards Inspectorate for Wales, have given people a whole set of clear expectations about what makes good services. There is clear evidence in this report of improvements in several areas. We were particularly concerned last year about

residential care for children and adults. One thing that we have sought to do, as an inspectorate, is focus attention on those. In that sense, it is not surprising that when you focus attention on an area, a greater set of requirements will initially be placed on services. The acid test for all this will be next year's annual report. Has the work that we have done with a number of settings by saying, 'Look, this is the position; we are very clear with you about what you need to do to change and we want to work and try to support you in that change', delivered dividends?

[207] On a personal level, I have spent time with inspectors in different parts of Wales recently, looking at services, particularly in west Wales and north-east Wales. I saw focused attention on particular services where there were difficulties, and those services changing. So, there are things that we can do directly through regulation, but your wider point that this cannot happen alone is important. There are around 1,200 to 1,300 care homes in Wales, which probably means that there are around 1,000 providers of care homes in Wales in total. It is still run very much as a small business. That has its own challenges and if we believe, as I do, that change can happen only from within those services, we have to ask ourselves whether we are doing enough to help those services to join themselves up together.

[208] It is not an accident that some of the improvement in early years services is associated with the commitment of bodies such as the National Childminding Association and Mudiad Ysgolion Meithrin, the Wales pre-school playgroup association, which give those services a framework, a quality assurance scheme, and support and development. I have been in discussion with bodies such as Care Forum Wales on the care home sector on how we can strengthen the links between what are a whole set of fragmented providers.

[209] Supporting providers in joining up is an important element, but the directions paper, 'Fulfilled Lives, Supportive Communities', also makes it clear that there needs to be a step change in commissioning. At the end of the day, most of these services are bought through the public purse, which is a major plank on which the directions paper hopes to build the sort of step change in services that it talks about. It is down to the right balance between what the provider, who owns the service and the quality, has to do and what we can do to support that. How can regulation help, and what does commissioning need to do to move that forward?

[210] **Lynne Neagle:** I have some questions on the section on day care. Jenny made the point that she did not think that inspection was working, but your report states that you feel that improvements have been made precisely because of the inspection of day care services. So, I was a bit concerned to read that there will now be quite a significant reduction in the number of inspections and a move towards more self-assessment. Will you expand on that? It is particularly worrying where small children are concerned, because they are obviously not in a position to complain about poor-quality services, as adults are.

[211] On childcare generally, the table shows that there are still significant disparities in some areas between the number of places for various settings. I am glad to see improvements in Torfaen, but Blaenau Gwent and Merthyr are still doing very poorly in the number of childcare places across all settings. Could you expand on what you said about certain locations having been identified as needing more settings? You have been told that staffing difficulties have prevented improvement, and you have also highlighted that planning authority requirements may have been at fault. Could you also expand on that?

[212] As you know, I have taken a particular interest in adult services with regard to care homes over the past year, because of the Beeches Nursing Home in Blaenavon. That case has been resolved following the tribunal. However, through your involvement with that case and the other homes that were linked through the owner of the Beeches, are there any lessons to be learned by your department and the Assembly Government about how to handle a situation where there have been serial problems in each of a group of care homes owned by the same

person, leading to the serious situation where closure orders have been made, and frail and vulnerable elderly people have had to be moved out?

[213] More generally on the care homes section, the second paragraph states that the improvements have not been sustained, and that there is a gap between what service users have a right to expect and what they are actually getting. Do you have any general observations on where we are going wrong with regard to care homes in Wales? What should the Assembly Government be doing to remedy the situation?

[214] **Mr Pickford:** I will start with the day care element. I am sure that you will come back to me if I miss any elements. It is important that we distinguish between inspection and regulation. No change is being made to the regulation. When I talk to providers, there is often a misconception that the regulations are made by this body, passed to me, and that I pass them on to the service. In fact, I am not part of that process; the regulations are made here. They then fall to be followed by the provider, in some senses, regardless of whether we ever turn up to carry out an inspection. That is an important principle that we hold on to. What we are saying is that, where there is evidence that the provider can show that it is capable of meeting the regulations, it is reasonable to reduce the inspection function. That does not mean reducing the regulations.

[215] The challenge in that is how to reach those decisions. One of the core elements of the reform of regulation is moving from the position that we had in 2002—where the model, in essence, was to inspect every setting as though it were the same, and to inspect every regulation in that setting—to, in essence, undertaking an assessment of needs. So, you look at what you know about that setting, such as its history from last year, the nature of any complaints, whether there is a high staff turnover, and whether the setting, by its nature, is vulnerable, and that should lead to the drawing up of a more targeted inspection activity.

[216] So, this is about our trying to understand the particular needs of particular settings. In relation to some early years services, particularly childminders, the conclusion that we came to in discussion with both Ministers—and we discussed it with Mrs Davidson too—was that, given that the inspection of child minders is something that takes a couple of hours, devoting perhaps a morning or a huge amount of time to designing an assessment process to decide whether you spend two or three hours there was not a good use of time. So, changing the frequency of inspection was helpful.

[217] **Ms Cooper:** Perhaps it is worth adding that the committee has had some discussion on the new regulations that have been proposed on the reform, which will mean that providers are responsible for their own quality-assurance processes, and being responsible for informing the Care Standards Inspectorate for Wales where they have met requirements. So, along with the changes that are happening for the regulator or the inspector, there are additional responsibilities and accountabilities placed on providers. They are happening in tandem.

12.00 p.m.

[218] **Mr Pickford:** They emphasise the importance of the provider in that, and there are tools that allow us to adopt a more proportionate approach. It is about proportionality. I know that there is a lot of debate around whether we need all this regulation, and whether there needs to be a lighter burden. We have taken the stance that there needs to be an approach that is proportionate to need. In some places, it needs to be heavier and in others, lighter.

[219] In relation to your question about places, what was interesting, when we looked at the figures, is that the pattern of day care for children is very different in different parts of Wales. For example, out-of-school clubs are a major part of provision in north-east Wales, but are not as great a part of provision in the Cardiff area. That may be as a result of careful thought and

planning, or it may be significantly influenced by history. When you look at the pattern of nursery education that existed in Wales prior to local government reorganisation, the old Glamorgan and Clwyd counties invested significantly in nursery education, and it is not surprising that that has had an influence on the subsequent pattern of services. Ultimately, what is the right pattern for those services is sensibly determined by people locally, and the early years partnerships are designed to do that.

[220] The other significant change is the new duty on local authorities to plan for an appropriate level of early years services, which comes into force in 2008, I think. The Act has been passed, but it does not come into force until 2008. The Act will place a new duty on local authorities to support that and to think about what they want for their part of Wales.

[221] In terms of the recent tribunal, it is fair to say that there is a range of different lessons, some of which you might describe as technical, because a tribunal such as that clarifies important points of law. To me, it emphasised that taking action of that nature is a major commitment by us and, most of all, it has a major impact on those who use the services and who are currently living there, and the relatives. The tribunal clarified that, where it is right and proper to take such action, such action must be taken, but there is a very high bar to take such action. Not only do we have to prove that regulations have been seriously and persistently breached, we also have to prove that it is in the public interest to take such action, that is, in the interests of current and future service users and of the wider needs of the population in that area. So it has clarified some of those issues.

[222] In respect of where there have been persistent issues, the tribunal clarified that we can only act in relation to an individual setting and service; we cannot come to a conclusion that a provider is not fit to provide services in general and therefore cancel the registration of the 50 homes that provider owns. However, the tribunal has identified that in considering a particular setting and difficulties in that setting, the performance in other parts of that organisation can be relevant in the decision. That was an important conclusion, because it was one of the issues that you were concerned about arising out of the original care standards tribunal decision on Holly House in 2005.

[223] The tribunal also asked the question whether, if enforcement of this nature is such a demanding and upsetting process for people, there are other enforcement tools that it might be appropriate for us to think about. It has been said to me that cancellation of registration is clearly a fairly nuclear option that one uses in the most extreme circumstances. The UK Government published a report, I think it was in the spring of last year, called the Hampton report, which was about the future of regulation and inspection across the piece. It was published by the Chancellor.

[224] It raised two important issues, one of which was whether the penalties for non-compliance are sufficient. If I ignore health and safety legislation and save myself £100,000, and I get a £2,000 fine as a result, rationally, you might conclude that I have saved £98,000 and that therefore non-compliance might be the thing to do. Therefore, is that balance right? The second issue raised was whether there ought to be a range of more flexible enforcement tools, and this report suggests that it would be helpful to have a debate on the matter in Wales. The Hampton report raises all sorts of other issues, such the use of fixed penalty fines. If we see a breach in regulations, at the moment, we can prosecute—the matter goes before a magistrate's court and the case can take 18 months before it is resolved. If we were to see a breach and were able to go in and impose some action straight away, however, that would feel more proportionate to the people there and, to be fair, to the provider, which may have made a serious but genuine mistake at that time. Those are quite tricky issues, which require debate, but they might be the sorts of issues over which, in coming years, the Assembly will find it useful to exercise its powers under the Government of Wales Act 2006. So I think that it would also be helpful to have a debate about what we mean by enforcement and whether we

have the right tools to deal with it.

[225] Your last question was on sustaining improvement and how that happens. I believe that change comes from within—it is probably the old-fashioned social worker in me. When I see services that have changed, it is usually because the organisation and, often, the manager, have decided that they are going to do something about it. A colleague and I visited a care home this summer where there had been some difficulties, but what was crucial in that setting was that a manager had got in there, grabbed it by the throat and sorted things out. The sorts of issues that we would have seen in many places, such as difficulties in attracting staff and residents' concerns, were turned around relatively quickly, because there was leadership and management in the service. Leadership and management, probably, are the crucial things that need to be there. Beyond that, I know that this committee has discussed issues about the workforce, and, clearly, you cannot deliver any of these services without an adequate and properly trained and supported workforce, which is probably the other big element that needs to be supported in that.

[226] **Jonathan Morgan:** I want to stick with the issue of enforcement, but—[*Inaudible.*]—as well as some of the issues of staffing at children's homes. You said in your report that, basically, there has been a 50 per cent increase—the figure is 21 per cent against last year's 14 per cent—in the number of homes that did not have a child protection policy or procedure that met the requirements of the regulations. You have gone on to say that—and this is what I think is probably one of the most shocking parts of the report—in relation to the risk assessment for children's behaviour, there has been an increase in homes that did not comply with the regulations from 21 per cent last year to 33 per cent this year. The implication is that possible risks to children and young people are not anticipated within a placement plan. That is a rather intellectual way of saying that there are children at risk in the setting in which they have been placed because the risks have not been assessed in the first instance. Within the sample that you examined, some 33 per cent of care home settings are environments in which children could be at risk, be it the risk of sexual abuse or of emotional problems—I notice your chart further down the report showing some of the child protection issues that have been brought to your attention, and the breakdown of those. This really is quite shocking, and it demands the Assembly Government's urgent attention, because we cannot allow this to continue.

12.10 p.m.

[227] I know that, when you talked about enforcement, you said that the threat of removing a licence is the nuclear option. I think that that threat should be used a bit more often, because these care homes should be under no illusion as to the seriousness of the information that you have been able to gather. If anything, it should give the Government a great degree of strength in responding to this. If it has to be draconian, I would urge the Government to be as draconian as it can be, because we are talking about the welfare and protection of a very vulnerable group of people in society. So, I would like to see us explore, with your advice, how this can be enforced.

[228] My second concern is about the appropriateness, particularly in terms of qualifications and experience, of staff working in the care sector and in care homes. You said that less than 40 per cent of the homes in Wales have staff who meet the standard of qualifications set by the national minimum standards, namely 80 per cent with NVQ level 3. This is about how we tackle that, because I would imagine that there are several challenges in ensuring that people are properly qualified. We either have to ensure that people are qualified before they are recruited or that they get their qualification within an appropriate timeframe once they are recruited. I suppose that the ideal situation is to ensure that they are already qualified before they are taken on. You told us that less than 40 per cent of homes have staff who meet the national requirement, but what proportion of homes have people who are

qualified prior to being taken on and what proportion of homes have individuals who are not qualified prior to being recruited but who then achieve that qualification within a very sharp timeframe? This area needs to be tightened up, simply because, as you mentioned, it is not just about qualifications, but also a range of other experiences. In terms of child protection issues, we may have people working in the care home sector who may be very well meaning and capable but who have perhaps not had experience of some of those issues that have been drawn out in this report and in previous reports. So, is there any more information about the qualifications and how and when people achieved those qualifications?

[229] **Mr Pickford:** The whole workforce and staffing issue is crucial. If you compare, for example, children's homes with care homes, there is a more positive picture in relation to staff training and qualifications in care homes than there has been in children's homes. That prompted us to wonder why that is the case. I think that part of the reason for that is that there has probably been a greater engagement of that part of the service in working together around some of these issues. The Care Council for Wales, for example, has been sponsoring the social care development network around Wales. I think that there are four different areas of Wales where employers, providers of training, under the aegis of the care council, have brought people together and asked, 'What is the problem?'. Sometimes the problem has been people not understanding that the training was available and, in some parts of Wales, sometimes the training has not been available. I remember that, in discussion with them over the summer, staff in north-east Wales were saying that one of the things that that partnership had given some children's homes in north-east Wales was an opportunity to share their experience and the difficulty, which has led to the development of new training programmes in that area that have then begun to address that difficulty. It may well be that the children's home sector, which is probably more fragmented, ironically enough, than the care home sector—it is smaller in size but it does not have an umbrella organisation such as, for example, Care Forum Wales, that speaks in one sense with one voice for it—needs more support in that. I know that you have had a debate in this committee and in Plenary on looked-after children, and some of the consultation around 'Towards a Stable Life and a Brighter Future' tries to tackle this issue. As I understand it, the consultation that is out at present, says that one of the ways of tackling this is through the registration of the children's workforce so that you will not be able to practice without being registered with the Care Council for Wales. You can build into that a set of expectations around training, qualifications and ongoing professional development.

[230] I understand that that consultation is out at the moment, with a proposal to make registration compulsory. It is probably that type of route that will get us there. It is the route that worked with the more established professions, such as nursing, and, more recently, social work and medicine—you cannot be one of these types of workers unless you are registered with a body. That requires for you and your employer to be committed to the training, so that is probably a key element. We are working with the Care Council for Wales to say that, if you can prove, as a member of staff, that you are properly qualified and trained in that area, there will be no need for us to check, because it will have been part of the initial registration. So, the issue must be attacked from what you might call the supply side, with regard to what is there in terms of training and education in the community in which you live, and from the demand side in terms of the registration of the workforce.

[231] In terms of your precise question about the qualifications of the people who come in, I do not know the answer. I am not sure how easy it is to get that information, but my colleague may have a view.

[232] **Ms Cooper:** There is some detail on page 33, but you are probably looking for more detail than that. When we look at a registration, we can impose a condition on it, saying that, within a certain period of time, you will need to have attained some qualifications. So, there is a way for us, until a new system is in place, to check what is happening in the sector. That is

there currently.

[233] **Mr Pickford:** For example, in terms of a manager, we have imposed such conditions, in that they must gain a qualification within a certain period of time. Child protection is a concerning and sensitive issue in this. The risk elements that are particularly talked about in this report are risks to daily life. We have been concerned that some of the policies and processes needed to make the delivery of that consistent are not there in all the places that we would want to see. That does not mean that individuals are not working hard to do that, but delivering these services is a complex business; you need a policy and process wrapped around it to ensure that it is delivered consistently. Without that, I may do that well as an individual worker, but my colleague may not get around it. That is where gaps and problems arise.

[234] In relation to the child protection issue in general, our concern is more that people need to ensure that the right policies and procedures are there for the same reason. One of the issues that emerged from a recent tribunal, where there was an attempt to argue that we should not worry about records, as they are bureaucratic, is that it was made clear that, in the complex world of social care in which we live, records are not only useful, but are also essential. In my professional life, as I have gone around, I have seen that there is often a link between the clarity of thought of the individual and their ability to capture some of that in one or two brief points. Some individuals who are not very clear never get around to putting things down on paper.

[235] On the staffing element, there have been some improvements in terms of checking the suitability of staff, but more energy needs to go into that and providers need to focus better on it. I take your point around enforcement, and it will be interesting to see how that pans out during this year.

[236] **Jonathan Morgan:** Would it be possible for a care home or a children’s home to take someone on who has not been checked by the Criminal Records Bureau?

[237] **Mr Pickford:** It would be a breach of the regulations—

[238] **Jonathan Morgan:** But could it happen?

[239] **Mr Pickford:** It could happen. It could also—

[240] **Ms Cooper:** There are some provisos around some services where you can work with former police checks and appropriate supervision. Under primary legislation, you would have gone through a protection of vulnerable adults check before you could start working in care homes, for instance. So, that is there.

12.20 a.m.

[241] **Mr Pickford:** In terms of recruitment, it is difficult. If you were to undertake a recruitment exercise, the checks would inevitably take a certain period of time, and you need to be able, frankly, to hang on to that member of staff. The regulations say that, in those circumstances, they must work under supervision. It is illegal, however, simply to recruit people and to do no checks—that would breach the regulations and numerous bits of primary legislation; you would be acting outside the law if you did that.

[242] **Karen Sinclair:** It is nice to see you again; I bent your ear outside for quite some time over coffee, but there are a few things that I want to talk to you about. On children’s homes, when we look at their distribution across Wales, Powys is well served, is it not? At the bottom of page 31 you make the comment that:

‘The distribution of children’s homes raised questions about the degree to which they are meeting the needs of a specific locality’.

[243] I will not read it all, but you also talk about the strain on local services, particularly specialist health services. I would like some comments on that, because it does not reflect the population spread, and in such a glaring manner that I wanted to ask about it.

[244] I then wanted to move on to adult services. Do you want to discuss them separately, Chair?

[245] **Rhodri Glyn Thomas:** No, that is fine.

[246] **Karen Sinclair:** I wrote what you said about regulation alone not being the answer, and I concur with that. Building quality into the system is imperative in the care sector. The care sector is keen and enthusiastic to take this agenda forward and to fly with it, because the slack in the adult care sector has gone. As partners with local government and with you, private providers must work collaboratively to ensure that best practice is rolled out. That is in the interest of the sector, and not just for the people being provided with care. These are exciting times on that issue.

[247] The care council and care forum are working on supporting managers and I wanted to talk about this. I strongly feel that this is imperative. Managers and owners are not necessarily the same people, as you know, so managers have constraints on both sides and can feel isolated and alone. We should be encouraging this forum, which brings them together and gives them the opportunity not only to roll out best practice, but to support each other. It should be taken forward into what Jonathan was talking about with regard to the children’s sector, because that would be enormously beneficial for everyone.

[248] In addition, I have looked at the care academy, which I think will work well in conjunction with your aspirations and ours for qualification and registration in the care work setting. How much work are you doing to roll out that sort of model across other sectors as well? Like the Welsh care awards, it is a carrot for people to work proactively. I return to what Jonathan said, and what I was bending your ear about over coffee—the nuclear option must always be something that could be triggered if it is needed. If people believe that it would not be activated, an awful lot of the sanctions that must be there are taken away. It is a question of balance between working with people and ensuring that they know clearly what can happen, is it not? I cannot imagine a situation at the moment where that response would be needed, but, occasionally, they must know that you have real teeth.

[249] **Mr Pickford:** There were a number of issues there. I will start with the distribution of children’s homes. One of the revolutions in social care over the last 10 to 15 years is that it has moved from being primarily provided by local government to being primarily provided by the independent sector. I recall, in relation to children’s homes, when I worked for Mid Glamorgan social services, I think that that county and Clwyd—although I cannot remember the exact percentage—provided three quarters of all children’s homes in Wales. We are now in a position in which almost three quarters of children’s homes are provided in the independent sector. In terms of that distribution, it is interesting that there is clearly a significant skew to rural parts of Wales; that is not what a process by which you sat down and said, ‘Now, I wonder where we want to put these children’s homes’, would have led to. It has certainly formed the basis of a lot of the discussion with stakeholders around the development of ‘Fulfilled Lives, Supporting Communities’. Is that a pattern of services that we want for children in Wales? I think that the conclusion to that was, ‘No, not necessarily’, which takes us back to the commissioning question of us being very clear, as people who commission those services, about what we want and where we want it. I suspect that it is unlikely that you

would say, 'We want to put the vast majority of our children's homes in Powys'. I think that it is probably the most unlikely conclusion to reach. I think that the information, hopefully, from this report, provides very useful background information to enable those sorts of decisions to be made.

[250] I agree with you very much on the issue of collaboration. In the early days of CSIW, Care Forum Wales, for example, set up a set of managers' meetings, now called 'essential updates'. People like me and my regional colleagues hawked our PowerPoint projectors around several of those meetings. Those meetings have carried on; for example, there are discussions now around the implications of the regulatory reform Order on fire, which is a significant change for care home providers, a number of which have some anxieties around this. There is a set of these managers' meetings and the fire service will play the main part in that. However, we go into those discussions to help managers understand what we think it means. We will also learn things from those processes. I believe fairly strongly that management does make a difference—I would say that, would I not? However, getting to those managers and supporting them, particularly where services are as fragmented around Wales as they are—it is not just a Welsh problem, but a UK issue—is crucially important. It is a lonely job and managers need support. If you are not working in a large organisation you need support around that.

[251] It raises issues, perhaps, about a wider definition of commissioning. I know, from discussions that I have had with bodies such as the WLGA, that they are interested in how they, as local government, can assist this process. The Care Council for Wales, for example, produces an induction framework for all new staff. We see and report that that is not, perhaps, applied as universally as it should be. Can commissioners—the local authority—get providers together in that area, as some of them are doing, to say, 'Why do we not run one set of induction programmes in this area against that framework, to which everyone can come along?', rather than feeling that they will do it for their staff while other providers do it for theirs? It is probably a better use of resources, but, more importantly, it is a better use of development time.

[252] In relation to the care academy, one of the issues in social care is that we are reluctant to blow our own trumpets—it is probably something about the sort of people who go into social care. I have had the pleasure, in the last couple of years, of going to the award ceremonies that you referred to, and also of going to the City Hall, last year, for the social care accolades, organised by the Care Council for Wales; I think that you were there, Minister. It was a very affirming sort of afternoon where you see people who have thrown themselves and their lives into doing this and you see what they have achieved. We probably need to do more of what we do well, as well as recognising that there are things to tackle. It may be something about social care, but we tend to say, 'I wonder what we have done wrong', rather than, 'Look at these things that we have achieved'; that may be something about wider human nature.

[253] It is unusual for me to agree with the North Korean Government, but I believe that there is a place for the nuclear option. There has to be a nuclear option. What we have to do is work closely with providers. We have been developing a set of methods to encourage what we call 'compliance'. We have not been simply saying to providers, 'Here is a set of things that you must do and we will come back in a year's time to check whether you have done it'; we have been identifying a set of key levers for change.

12.30 p.m.

[254] One issue that we have wrestled with since 2002 is that when we were expected to check every regulation, that actually had a disempowering effect on people. I have thought about this in terms of how you manage staff. If I was to say to a member of my staff, 'I am

very sorry to say that there are 40 things wrong with you', they might say two things: 'It is a shame that you did not tell me before, Rob', and, 'There must be one or two things that are more important or more crucial than that'. Yet, the model of regulation of the 1990s and early twenty-first century actually assumes that that is the case. When a provider has a problem, the system has been saying, 'Here is a whole set of other things that you have to do as well'. Part of the reform of regulation is our trying to identify some key levers for change, which may be, for example, that the provider of the care home should sort out the management.

[255] There are some risks in that because we know that people who use services, and their relatives, may well turn around—not simply to us as the inspectorate, but also to the Welsh Assembly Government and the Assembly—and say, 'Although there are all these regulations, your inspectorate did not check that, and that is exactly the stone that my mother tripped over and she suffered as a result'. We have to be fairly brave about that and say that conforming to the regulations is the responsibility of the provider, and we are going to target our energies at where they are most needed and at where they can make the most difference. There is a need for a nuclear option, but we also have to become more sophisticated about how we use other tools.

[256] **Karen Sinclair:** You were talking about collectively working on induction, but a lot of work goes well beyond that to working collectively on upgrading the care staff sector, which allows for career pathways, for example. I feel strongly about that. In the past, because there was a lot of competition, I think that people paid the price in that they lost staff because there was no career development, and they were scared of talking to one another about pathways that did not necessarily go just through one business but crossed over for the benefit of all. That work is being done now and it should be applauded. I am feeling quite upbeat about it.

[257] **Mr Pickford:** I think that the Minister's foreword to 'Fulfilled Lives, Supportive Communities' asks that question: what sort of balance do we want? Who do we want to provide these services? I am sure that the Minister can speak for himself, but my understanding of what he raised is that, in all certainty, there will be a mixed model of service provision. What that means is that, for the foreseeable future, social care in Wales will be significantly provided by the independent provider sector. There are two ways in which we can treat that. One is probably what you might describe as the Victorian model of capitalism—let the devil take the hindmost—and the other is that we could say, as I think most modern organisations do, 'I need to worry about my supply chain; if I am going to be commissioning for these services, I need to be concerned that the people who are providing them are fit, that they work together, that we build on their strengths and that we co-operate'. You do not see a modern multinational company simply saying, 'I could not care less about my suppliers'; such companies nurture, look after and help their suppliers to grow. I think that there are important lessons to be learned from that, and that collaborative model is absolutely crucial.

[258] **Karen Sinclair:** May I just say, to put it on record, that my first choice would not have been to go down that road in the first place? However, given that we are down that road, we need to work to get the best quality out of it.

[259] **Rhodri Glyn Thomas:** Diolch yn fawr i Rob a Natalie am ddod i mewn i gyflwyno'r adroddiad. Fel y gwelwch, mae'r Aelodau wedi dangos diddordeb mawr yn yr adroddiad a chredaf fod nifer o bwyntiau pwysig wedi'u codi yn y drafodaeth hon y gellid eu datblygu ymhellach.

Rhodri Glyn Thomas: Thank you very much to Rob and Natalie for coming in to introduce the report. As you can see, Members have shown great interest in the report and I think that many important points have been raise in this debate that can be developed further.

[260] Yr wyf am ddweud bod tri phapur i'w nodi a chyda hynny, gallwn gau'r cyfarfod. Diolch yn fawr i chi i gyd.

I wish to say that there are three papers to note and, with that, we can bring the meeting to a close. Thanks very much to you all.

Daeth y cyfarfod i ben am 12.34 p.m.
The meeting ended at 12.34 p.m.