Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

29/09/2016

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Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd. Lle y mae cyfranwyr wedi darparu cywiriadau i'w tystiolaeth, nodir y rheini yn y trawsgrifiad.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included. Where contributors have supplied corrections to their evidence, these are noted in the transcript.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad|Biography	Plaid Cymru The Party of Wales
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
Angela Burns Bywgraffiad|Biography	Ceidwadwyr Cymreig Welsh Conservatives
Caroline Jones Bywgraffiad|Biography	UKIP Cymru UKIP Wales
Dai Lloyd Bywgraffiad|Biography	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Julie Morgan Bywgraffiad|Biography	Llafur Labour
Lynne Neagle Bywgraffiad|Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Neil Ayling	Llywydd Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru a Phrif Swyddog Gwasanaethau Cymdeithasol Cyngor Sir y Flint President of the Association of Directors of Social Services Wales and Chief Officer of Social Services at Flintshire County Council
Mair Davies	Cyfarwyddwr ar gyfer Cymru, y Gymdeithas Fferyllol Frenhinol Director for Wales, Royal Pharmaceutical Society
Dr Jane Fenton-May	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners

Richard Lee	Cyfarwyddwr Gweithrediadau, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Director of Operations, Welsh Ambulance Services NHS Trust
Claire Marchant	Cyfarwyddwr Arweiniol Gwasanaethau Newydd a Phrif Swyddog Iechyd a Gofal Cymdeithasol Cyngor Sir Fynwy. Lead Director of New Services and Chief Officer of Social Care and Health at Monmouthshire County Council
Tracy Myhill	Prif Weithredwr, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Chief Executive, Welsh Ambulance Services NHS Trust
Dr Mair Parry	Coleg Brenhinol Pediatrig ac Iechyd Plant Royal College of Paediatrics and Child Health
Suzanne Scott-Thomas	Cadeirydd, Bwrdd Fferylliaeth Cymru y Gymdeithas Fferyllol Frenhinol Chair, Wales Pharmacy Board of Royal Pharmaceutical Society
Dr Isolde Shore-Nye	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Professor Tayyeb Tahir	Coleg Brenhinol y Seiciatryddion Royal College of Psychiatrists

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

Sarah Beasley	Clerc Clerk
Claire Morris	Ail Glerc Second Clerk

Sarah Sargent	Dirprwy Glerc Deputy Clerk
Dr Paul Worthington	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:31.
The meeting began at 09:31.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datganiadau o Fuddiant
Introduction, Apologies, Substitutions and Declarations of Interest

[1] **Dai Lloyd:** A allaf i eich croesawu chi i gyd i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad? A allaf estyn croeso i fy nghyd-Aelodau, ac a allaf egluro i bawb fod y cyfarfod yma, fel pob un arall, yn ddwyieithog? Gellir defnyddio'r clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf hefyd atgoffa pawb i ddiffodd eu ffonau symudol ac unrhyw offer electronig arall achos maen nhw'n gallu ymyrryd â'r offer darlledu? Nid ydym ni'n disgwyl larwm tân i ganu, felly os ydych chi'n clywed larwm tân bydd angen dilyn cyfarwyddiadau'r tywyswyr a gadael yr adeilad. A allaf i nodi ymhellach hefyd ein bod ni wedi cael ymddiheuriadau gan Dawn Bowden am y cyfarfod yma?

Dai Lloyd: May I welcome you all to the latest meeting of the Health, Social Care and Sport Committee here in the Assembly? Can I welcome my fellow Members and explain to everybody that the meeting, like every other meeting, is bilingual? Headphones can be used for simultaneous translation from Welsh to English on channel 1, or for amplification on channel 2. May I remind people to turn off their mobile phones and any other electronic equipment, because it can interfere with the broadcasting equipment? We're not expecting a fire alarm, therefore if you hear a fire alarm, you'll need to follow the instructions of the ushers and leave the building. Could I note further that we've received apologies from Dawn Bowden for this meeting?

09:32

Ymchwiliad i Barodrwydd ar gyfer y Gaeaf 2016/17—Sesiwn Dystiolaeth gydag Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Inquiry into Winter Preparedness 2016/17—Evidence Session with the Welsh Ambulance Services NHS Trust (WAST)

[2] **Dai Lloyd:** Felly, gyda chymaint â hynny o ragymadrodd, fe wnawn ni symud ymlaen i eitem 2 ac ymchwiliad y pwyllgor yma i barodrwydd ar gyfer y gaeaf, ac mae gennym ni sesiwn dystiolaeth nawr gydag Ymddiriedolaeth y Gwasanaeth Iechyd Gwladol Gwasanaethau Ambiwlans Cymru am y tri chwarter awr nesaf. Croeso i Tracy Myhill ac i Richard Lee—croeso i'r cyfarfod. Rydym ni wedi darllen eich papur chi ac mae yna gyfres o gwestiynau ger bron y buasem ni'n hoffi clywed yr atebion iddyn nhw, yn seiliedig ar y papur yr ydych chi wedi'i gyflwyno. Felly, gyda chymaint â hynny o ragymadrodd, awn ni'n syth i mewn i gwestiynu, os ydy hynny'n iawn. Fe wnawn ni ddechrau, yn sylfaenol, efo fi. Yn gyffredinol—rŷch chi'n gwybod y pwnc—pa mor barod ydych chi, a ydych chi'n credu, gogyfer peryglon a heriau sylweddol y gaeaf yma?

Dai Lloyd: Therefore, with that introduction, we'll move on to item 2 and the inquiry of this committee into winter preparedness, and we have an evidence session now with the Welsh Ambulance Services NHS Trust and that is for the next three quarters of an hour. Welcome to Tracy Myhill and Richard Lee—welcome to the meeting. We have read your paper and we have a series of questions before us that we'd like to hear the answers to, based on the paper that you have submitted. Therefore, with that introduction, we'll go straight into questions, if that's okay, and we'll start, basically, with a question from myself. Generally—you know the subject area—how prepared are you, do you think, for the challenges and risks associated with this winter?

[3] **Ms Myhill:** Thank you very much. I think it would be fair to say that the Welsh ambulance service is in a much stronger position this year than it was last year, and last year it was stronger than it was the year before. So, the organisation itself has made significant progress in terms of its leadership, its engagement with its staff and, of course, since October of last year, we've been operating a new clinical response model—the pilot clinical response model, which you will know about, and that is going to help us significantly

in terms of prioritising the most ill patients that we need to respond to. So, from an organisational point of view, you will see from the performance that we have been able to deliver that we are definitely in a much stronger place.

[4] In terms of our planning for winter this year, again our approach to planning has been different and we have learnt from last year, so our approach this year has been much more based on demand and patterns of demand. Previously, you will have seen winter plans for the ambulance service and they would be about keeping vehicles safe, keeping vehicles on the road, making sure we've got snow tyres, which are all very important things, but this year there's been much more of a focus on, 'So, what was the demand last year? What happened to it? What sort of patients did we have? What sort of numbers? What was the mix of the different types of patients?', and we've used that demand analysis to determine what we need to do. I think the other thing I would say that is different is we've worked much more closely with our partners across the health and social care system because, if we're perfect, we still can't deliver without being part of the system. So, we have integrated plans with the seven local health board areas, as well as our own national plan.

[5] **Dai Lloyd**: Dyna chi, diolch yn fawr iawn am yr ateb cynhwysfawr yna. Bydd yna ddigon o amser nawr i Aelodau ddrilio i lawr am y manylion roeddech yn sôn amdanyn nhw. Fe wnaf i ofyn i Caroline Jones ofyn y cwestiwn nesaf. Caroline.

Dai Lloyd: There we are, thank you very much for that full answer. There'll be plenty of time now for Member to drill down for the details that you mentioned. I'll ask Caroline Jones to ask the next question. Caroline.

[6] **Caroline Jones**: Yes. You have the pilot scheme that's been extended further. I'm looking at the 65 per cent target. Do you think that the 65 per cent target is ambitious? Do you have any detail regarding the 35 per cent of that target that is not met and how it has affected patients and, possibly, the families?

[7] **Ms Myhill**: I'll start and then I'll ask Richard to add, if I can. I think the 65 per cent target for red calls—. I'm sure you're aware that the difference in the model now means that those red calls are 5 per cent of our work. They really are the most immediately life-threatening calls. We've been able to achieve that target now for 11 months. We've been improving our ability to achieve that target, not just at a Welsh level, but across the whole of Wales. So, it's probably not ambitious enough, but I think it will really be tested now

over the next six months. This is the time of the year, we know, between October and March, sometimes even beyond March, where we will test that target. But we are planning to meet that target through the winter. If you look at the figures last year, we did, but only just, particularly in March, which was a very challenging month for us last year. So, I think it's the right target at the moment, but in time I think we would want to be more ambitious than that.

[8] **Dai Lloyd:** Rhun.

[9] **Rhun ap Iorwerth:** Just a supplementary on that, it's five—

[10] **Dai Lloyd:** Oh, yes. Sorry, Richard, did you want to add?

[11] **Mr Lee:** Sorry—

[12] **Caroline Jones:** [*Inaudible*.]—up from the other 35 per cent that wasn't met.

[13] **Mr Lee:** I think it's important to reassure the committee: we don't plan our services to reach 65 per cent of red calls and then stop. As you see, we are increasing the element by which we overachieve against the 65 per cent target. The ambition of my operational teams is to get to as many of these life-threatening calls as quickly as possible. So, the 65 is the target, but as you can see, we are overachieving on that by some margin and we will continue to do that across the winter, as far as we can.

[14] As far as the effect on patients, we know that, for patients in cardiac arrest, their chance of survival reduces by 10 per cent per minute before a defibrillator is applied to them. We know that waiting for an ambulance is a very frightening experience—minutes seem like hours when you're waiting. So, as well as recording our performance against the 65 per cent target, we also measure our performance minute by minute. At 10 minutes, we are at around 85 per cent to 90 per cent of calls—it varies slightly, month to month. So, our 10-minute performance is better than our 8-minute performance, and our 15-minute performance is better than our 10-minute performance. There will always be a tail-off in response, especially in very sparsely populated areas. One of the very important things about the way we are managed is that the target is universally applied across Wales—there are no geographical distinctions—and that's really important as far as equity goes.

[15] To take the second part of your question about clinical information, last year, we were lucky to receive investment for a new system of digital pens. So, our ambulance crews record information on patient report forms and that now feeds into a database, so we can extrapolate much better information. Two of the key indicators that we look at are stroke and heart attack, where we look at actual whole-system data. So, we don't just look at what was the ambulance component, we look at when you got to hospital, what happened to you in hospital and what was your outcome sometime later. So, I think we're able to be quite reassured that the whole-system data support the fact that we're playing our part in the system.

[16] **Dai Lloyd**: Ocê, diolch yn fawr. Rhun. **Dai Lloyd**: Okay, thank you very much. Rhun.

[17] **Rhun ap Iorwerth**: Red calls are 5 per cent, you say, of your total calls. So, there are no targets, by now, for 95 per cent of the calls that come in. How do you measure your performance within that 95 per cent?

[18] **Ms Myhill**: It's quite interesting, because the reason that 5 per cent of the calls are based on a time target is because the clinical evidence is that for that category of call, time is absolutely critical—those minutes, as Richard has said. So, for the rest of the work that we do, we're not measuring time where time doesn't have a discernible impact on the outcome—what we're measuring is patient experience and clinical indicators. Richard has mentioned stroke—if you've had a stroke, we want to make sure we get you to the right unit in the time that you need to be in the unit, which is usually an hour, to receive what you need for your condition. So, we're measuring more information on that 90 per cent that you've noted than we've ever done before. So, the ambulance quality indicators that you might have seen that we publish now every quarter at each health board level, as well as at a Welsh level, give a whole raft of information about the service that we provide to the bulk of our work.

[19] **Rhun ap Iorwerth**: You could see targets as benchmarks as well, of course. How do you benchmark those performance indicators?

[20] **Ms Myhill**: In terms of the time target, the system that we have is probably unique, actually, at the moment, in terms of the clinical response model that we are operating—it's being watched by people across the bridge and across the world. So, we haven't got exactly the same systems, but there

are ways of benchmarking, particularly those very, very severe calls. The system in England, for example, has got a red 1 and a red 2, so we will look at what we do compared to the red 1 category in England. But, again, the systems are slightly different.

[21] **Rhun ap Iorwerth**: But you will publish time figures as well.

[22] **Ms Myhill**: Sorry?

[23] **Rhun ap Iorwerth**: You will publish data on time as well as clinical outcomes.

[24] **Ms Myhill**: We publish data on the amber calls, which is about 60 per cent of our work. The main measures there are about patient experience and outcome, but we still need to keep an eye on time, because that's quite important. So, internally, we will measure 20 minutes on those amber calls.

[25] **Rhun ap Iorwerth**: And they are published then.

[26] **Ms Myhill**: They are published, yes.

[27] **Mr Lee**: In the monthly statistical release, similar to the one that was released yesterday, there is time-banded performance for amber calls—it's not a target, but it's information that we publish because it's important. As I say, waiting for an ambulance is a desperate time. Just to back up what the chief executive said, our previous obsession with time targets in the UK for ambulances actually drove poor behaviour by ambulance services. So, if somebody in your constituency is having a stroke or a heart attack, us sending a paramedic in a car to help them does not actually help them get the definitive treatment, get them well and get them home again to the community in a good functional state.

[28] There are a really small number of emergencies—the 50 that we attended yesterday; the 50 red calls yesterday—where minutes really did make a difference between that person living or dying. For the rest of the calls, it's far more important that we send the right thing—the right people in the right vehicle—to do what's needed for that patient and take them to the right treatment.

[29] Heart attack patients—when I was first a paramedic in the mid-1990s, we were thrombolysing, we were taking them, they were spending two weeks

in hospital and they were being discharged with heart failure. We're now taking those patients direct to a catheter lab and three days later they're back home better. So, the system is much less now about how quickly we get to people—it's much more about sending the right thing. So, one of the things we do benchmark is who we send to emergencies. We are trying to reduce the number of occasions where we send a paramedic in a car and increase the number of occasions where we send an ambulance with a paramedic in it who can look after the patient's whole needs.

[30] **Dai Lloyd**: Good. Julie.

[31] **Julie Morgan**: Yes, thank you very much. I think this is the right move—to reach the people who are most urgent and need the time is absolutely right. But I do think that the amber area is the area that does produce most controversy and concern. As you know, I've had a number of patients who've had to wait a long time for an ambulance, and they were not classed as red. My fear was that the experience of waiting so many hours may, perhaps, make them red in the end. So, I really think it's very important, as Rhun has said, that we do have an analysis of what's happening with the amber calls.

09:45

[32] I'd also like to say that I think your response has been very good to the complaints that I've put in about them. You've been very direct with the patients, offering to go to see them personally, and sending a lot of people to see me personally, because I had a little run of people. I think it's really important that we do avoid that. So, could you tell me what your actual plans are to make it less likely that people in the amber category who appear to be not life-threatening don't wait for hours and hours, which, as they're often elderly, is very concerning?

[33] **Mr Lee**: Absolutely. So, we are doing two pieces of work at the moment. One piece of work, which comes to an end in October, is in association with the Association of Ambulance Chief Executives, which is the UK body. We are undertaking a demand and capacity analysis, and that's specifically looking at the level of resourcing we require to send the ideal response to every emergency call. We have put some notional time boundaries in that to do the analysis against. So, that piece of work is going on at the moment, health board by health board area, and the information will be available to us and our commissioner in late October.

[34] That's the strategic piece of work. The local piece of work and the tactical piece of work is about looking at the amber patients and being quite relentless at analysing the tail of responses. One of the advantages of the new model is that we can be much better at looking at the red incidents. So, every red call that we don't get to in eight minutes every day is now reviewed on a case-by-case basis. In the previous model, we couldn't do that because there were so many of them. It would have been an industry in itself. For the amber calls, we know that the heart attack and stroke patients wait the shortest amount of time because they are the highest priority within the amber group, and we have identified some categories of amber patients who are sometimes waiting longer than they should. Some of those are elderly people who have fallen, and some of those are people with isolated limb injuries; so, people who have broken their arm, people who have broken their leg.

[35] Now, it's not right that anybody waits too long for an ambulance, but it is reassuring that we're getting to the heart attack and stroke patients quicker than we're getting to somebody with a broken arm. That is good news, and that shows that the model is doing what we thought. So, as part of our winter plan, you'll see that we're looking at new ways of managing patients, especially elderly fallers. One of the things we're doing—you'll have read in our evidence about our clinical support desk. So, we now have a team of 18 paramedics and nurses who assess patients over the telephone and provide alternatives to us sending an ambulance. Last month, 907 ambulance dispatches were prevented by the nurses and the paramedics on that desk. That means that there were 907 ambulances available to go to amber calls that previously weren't available.

[36] We know that elderly fallers can't be managed over the telephone because they've fallen and they need help. So, we have equipped 15 of our community first responder teams with the necessary equipment to lift patients from the floor. That's really important because when we talk to our community first responders, they say to us, 'We're really happy to go to the red calls in our community and save life, but, actually, we hear, when we go into the Spar shop in the village, somebody saying to us, 'Where were you the other day when my mum fell over and we waited 45 minutes for an ambulance?' Well, historically, we've not used CFRs for that, and we're going to this winter.

[37] So, the clinical desk will provide some initial safety-netting, and once

the clinical desk are happy that the patient isn't injured, the community first responders will attend to help the patient off the floor, and then the clinical desk will then provide a follow-up assessment and a referral by telephone on to the local falls service. That is going to transform the experience of those fallers. It's also going to give us more ambulances available to go to other amber calls, where it is not acceptable to send a first responder because the patient's going to need something more than a first responder can offer.

[38] There's also some work going on about our ambulance availability. We know that our peak demand now starts at 10 o'clock in the morning. Historically, we thought our demand peaked up about 2 o'clock in the afternoon and went through to the early hours. The demand and capacity work we've done already has shown us that, actually, we are at peak demand from about 10.00 a.m. onwards. So, we're looking, at the moment, at what we can do about moving our peak staffing forward into the early part of the day, not the late part of the day.

[39] Lastly, I think you'll have seen from our plan that a huge part of our plan is about returning capacity to the front line. So, for managers, like myself, who are paramedics, part of the winter plan is about putting us to do some clinical work for some of the time, which will increase the ambulance availability and will reduce the amber waits.

[40] **Julie Morgan:** Can I just ask about the falls and elderly people having to wait? Do those increase in the winter? Do you have any evidence?

[41] **Mr Lee:** Yes, they do. What we find, in the winter—. If you look at last winter, for our call volume on all 999 calls, on a month-by-month basis, there was a variance of about 3,000 calls between the quieter months and the busier months. So, there's not a massive—you're talking about 100 incidents a day—spike in demand. What we find is the acuity changes. So, the number of calls that are red stays the same—people don't become more life-threateningly ill in the winter. What happens is that our green calls, the very minor calls, reduce, and the amber calls in the middle increase. Most of those are either people who've fallen or people with respiratory conditions who maybe in the warmer months would have been categorised as a green call and been suitable for telephone assessment, but in the winter, the person now has a chest infection and is septic and requires an ambulance response. So, that's the pattern that we see.

[42] **Dai Lloyd:** Okay. Lynne.

[43] **Lynne Neagle**: Thanks, Chair. I'm really pleased to hear that the work is ongoing with the fallers—as you know it's been an area of concern for me, and I think that's really positive that you're looking at innovative ways to deal with it. I just wanted to ask about the capacity and resource review—I'm waiting with bated breath to see what it comes up with for Torfaen. I just wondered, if that review finds that you do need significant extra resource, will it be the intention of the commissioners to go to Welsh Government to ask for more money?

[44] **Ms Myhill**: We're doing this in conjunction with the commissioners—so the emergency ambulance services committee, which is made up of all the chief execs, as you know, commission the ambulance service from us. So, we're doing that together, and they're involved in the review, and we will collectively consider the outcomes from the review. I'm confident that the review will also show us where we can be more efficient. So, it's not just going to be about, 'We've got gaps and we need more'. I'm sure there will be some advice for us where we can be better at what we do with what we've got. If we see, through that review—. What we're hoping the review will tell us, to achieve certain outcomes and to achieve certain performance—it will tell us what we need where. We're doing it at very local level, as you know. So, it's not a national picture, it will be local level and building that up. Then we will have those conversations in terms of how we move from where we are to where we need to be—I would suspect, over time, as opposed to immediately—if there are areas where we've got gaps. It will help us prioritise also where we need to maybe shift resource or invest resource in the future.

[45] **Dai Lloyd**: Okay. Angela, did you want to ask at this point—? I'll give you the floor for a couple of microseconds.

[46] **Angela Burns**: Thank you. I wanted to ask a couple of questions on your paper. I couldn't have agreed more about your commentary on the resilience of the wider unscheduled care system and particularly your view that pumping more money into the NHS isn't necessarily the answer, but it's about making sure that that network and web is entirely in place. You talked in your paper about being an integral part of the unscheduled care services with the local health boards, and I think, Tracy, you mentioned the fact that you have integrated plans with each and every health board. Nothing in life is perfect, though—where are the holes?

[47] **Ms Myhill:** I think there are challenges that you will know and you will have seen and you will have heard. So, yes, we've got integrated plans with all of our health board colleagues and I know that our health boards are also working across the system with social care and others. So, the plans are definitely more joined up than they've ever been. That doesn't mean that there aren't pressures and we do have pressures in certain parts of Wales. North Wales is a pressure point for us on times, and you'll see that again from some of the published performance—

[48] **Angela Burns:** My apologies. I wasn't trying to get you to name and shame any other LHBs, I was thinking more about holes in the integration, in terms of—. So, for example, when you're trying to refer someone—when the ambulance has arrived there and you're saying, 'Well, actually, I don't think you need to go to hospital, you need to go and see somebody else'—are you finding those 'somebody elses'? Is there good accessibility to other services, to be able to signpost people? Sorry, I meant more those kinds of gaps in the system.

[49] **Ms Myhill:** Yes, okay, thank you. So, we would call that alternative pathways in terms of the way that we would describe that work. So, there are a number of alternative pathways that we've been developing collectively with health boards to help us avoid taking patients to emergency departments where emergency departments are not the right place for them anyway, but also it just potentially adds to the pressure. So, there are a number of common pathways that we have—falls is an example, diabetes is an example, and epilepsy is an example that we've got across the whole of Wales.

[50] Another example of a pathway we've got in Cardiff and in some other health board areas is mental health. So, if you're in mental health crisis, the last thing you need is to go to an emergency department. It's just not good for you, is it, as a patient, and it takes so much longer to get you the right care you need if you go through that route. So, in Cardiff, for example, we've got direct access to a mental health crisis team, so our people can refer directly to that team, and we have seen the hours that that has taken off some patients' journeys because they're getting the right expertise. We're looking to develop a few more in the winter now; diarrhoea and vomiting is another example, and flu. So, we are working across Wales to get direct access to district nursing, which is another example. So, there are good examples.

[51] There are some that are happening everywhere, there are some that are happening in some parts of Wales and not everywhere, and through our work with the commissioner and the emergency ambulance services committee we have an opportunity to say, 'That is really working there'. So, the Cardiff mental health pathway is not perfect either—we could still improve it—but that's a good pathway; let's move that and share that. We've done that with Aneurin Bevan, we've done it with ABMU in Swansea. So, we've got an opportunity through the system to share so that, where it works, we do it once for Wales wherever possible.

[52] **Angela Burns**: Thank you. The interest that I have is in how we might be able to stop people getting to the front door of the hospital—so, looking at all of the different alternatives. Obviously, as the first responders and as trusted professionals, you're going to be somebody that—. Your organisation is going to be an organisation that a potential patient will listen to and will follow your advice. So, I'm kind of interested in a few other things in that same area. Does the ambulance service just deal with a patient and that's it—their data, if you like, are dead to you? I notice you mentioned frequent callers, but do you have any data that can indicate the revolving door syndrome, where you're taking patients up to the front door and they're going in for a few hours, and then you're having to take them back out again, which of course is a huge drain on your resources? Do you have any data that might indicate what they do in those few hours, and is there anywhere else that we could be putting them rather than in a hospital? I'm interested in that whole short-term revolving door syndrome, and if you have any data, information or just any intuition that you could share with the committee on that.

[53] **Ms Myhill**: I think—you can add a bit more detail, Richard, if you would—but I think generally where we have been historically is we've been very insular, so our data have been our data and they've been recorded manually across the whole of Wales. It's been very difficult to join that up with the rest of the care system. So, our data—Richard mentioned digipens—are now digitalised, which makes it much easier for us to do a clinical audit or to work with our staff to understand what's happening. We are working in conjunction with health boards and Welsh Government to join up the system so that we can follow the patients right through the system. Quite often, for our crews—and I go out with crews regularly; people will know that I do that, and I say, 'What's happened to Mrs Jones?' and they say, 'Well, we don't know', and I say, 'Well, I want to know. I want to know what happened to her once we took her to the hospital'. So, there's definitely a system piece of

work that we are doing to try and join that up.

[54] In terms of the reality on the ground now, and intuition and feeling, you could probably say a bit more on that.

[55] **Mr Lee:** If you look at our whole 999 workload, we take about 63 per cent of the people that dial 999 to hospital, and some of those patients are helped over the telephone, so once you take away the ones that were helped over the telephone, we take about seven out of 10 people that we actually go and see face to face somewhere. Not all of those patients go to the emergency department. We're increasingly taking people to other parts of the hospital, so we take pregnant ladies direct to maternity, we might take mental health patients to a mental health clinic, and we might take patients with a fractured neck of femur to a trauma ward, directly bypassing the emergency department.

[56] In terms of your question about the gaps, the big gap is the use of our service by care homes. So, we have lots of calls to nursing homes to attend to patients, and there are registered nurses in nursing homes, and I think there's more work for us to do as a system to keep people in their nursing home. That is, after all, their home; that's where they live. If I was living in a nursing home, I'd want to live there. So, it's about keeping those people there and finding strategies. So, we're looking at the moment at developing community paramedics that will work in an area and will work alongside the district nursing team and alongside falls teams to maybe provide a bit more of a virtual ward system. So, instead of you being taken to hospital, they might pop in and see you a couple of times and just see how you are.

[57] The other issue you raised about people going in and coming out again, that's a real problem, because we don't bring people home from hospital anymore. We used to; we don't do that anymore. So, if we take somebody to hospital and then they need to come home again, quite often, getting them home is quite an art. So, we have to find new ways of not repeatedly taking people that don't need to go to hospital. So, our frequent-caller programme at the moment is looking at our top-10 frequent callers in each health board area, and is helping literally hundreds of patients—there are 400 and something patients in the programme at the moment. And it's not about—. You'll have read in the paper that two people have had a custodial sentence for abusing our service, but the vast majority—all except two of the patients in the programme—have had individual care plans agreed. So, we will talk to their GP. The GP, quite often, is unaware that their

patient is calling an ambulance every day. We'll talk to the district nursing team, we'll talk to the falls team, and this then allows us to have an individual treatment plan, which means that that patient doesn't end up in that revolving door arrangement.

10:00

[58] **Julie Morgan:** Can I just follow that up?

[59] **Dai Lloyd:** Sorry, everybody's—.

[60] **Angela Burns:** [*Inaudible*.]

[61] **Dai Lloyd:** If it's still on this point, yes.

[62] **Julie Morgan:** It was just particularly on frequent callers—

[63] **Dai Lloyd:** Go on, then.

[64] **Julie Morgan:** --because I was coming to that later on. I think you said—did you say had 400 people who were on—?

[65] **Mr Lee:** There are 400 people in the programme at the moment, but the thousands of ambulance journeys—3,000 hours—

[66] **Julie Morgan:** Yes. I've experienced a lot of this in my area, and, again, your response and explanations have been very good. But how many are you not reaching who are doing the frequent calling, because I'm getting repeated complaints from neighbours saying the ambulances are there every night, twice a night? And this, in one case, has gone on for two weeks. So, I wondered at what point do you intervene and are able to try and address the real needs of the person who's calling the ambulance.

[67] **Mr Lee:** So, we intervene at four calls in a month, or five calls over a two-month period. And the reason for that is that there are sometimes patients, especially end-of-life patients maybe, who become a super-user of ambulance services for a couple of weeks, and that is unavoidable. Or we find patients who are usually cared for by their family, and maybe the family go on holiday, and we have to fill a gap for a couple of weeks while that person's family aren't around. And, sometimes, people that aren't very well, especially older, frailer people—we may find we go to the same patient two

or three times in a week, and help them while they're unwell and then they get better and we don't hear from them again.

[68] The triggers we use to do the frequent-caller work: we're part of a national UK network of ambulance frequent-caller work, and the triggers are UK-agreed. I should say that one of the advantages of NHS Wales, with us being in this integrated system, is that our plans are much more whole-system plans, involving the GP and other services, where in England, the frequent-caller work tends to be that the ambulance service writes to the GP or writes to the community service, saying, 'This patient is now a frequent ambulance caller.' We don't do that; we get a multi-disciplinary team together, because we're integrated, and actually come up with a plan and a solution.

[69] **Julie Morgan:** Thank you.

[70] **Ms Myhill:** There's some real data on that that we can share that show the significant reduction. In January, for example, 71 patients called us over 400 times in that month—the same patients. We did this work across the system, as Richard has described, and by April the same 71 patients called us 100 times. So, a significant reduction in trying to access our services.

[71] **Dai Lloyd:** On that point, Rhun, and then Angela.

[72] **Rhun ap Iorwerth:** Is there a peak in the incidence of frequent calls over winter?

[73] **Mr Lee:** No. The call volume rise is to do with that shift in acuity, as I said, so the people that in the summer are green calls become amber calls in the winter.

[74] **Dai Lloyd:** Angela.

[75] **Angela Burns:** Two quick questions on winter pressures. The first, actually, Chair, is slightly to you, which is the point you made about the care homes, because of the fact that, during the winter, more people slip, particularly the elderly, and go into hospital, one of the big worries is that a number of those people will have some form of dementia. And I think the evidence very clearly shows that once you take someone out of their established routine and put them into hospital, their dementia increases exponentially and it's very hard then to row back and get them back into—.

So, then we have all those other ongoing social areas. So, I just wonder if our winter pressures inquiry ought to just have a quick look at the care home element of what we might be able to do, or see how prepared they are for winter pressures.

[76] **Dai Lloyd:** And possibly invite the umbrella organisation for care homes, yes. Okay.

[77] **Angela Burns:** Yes. But the other question I wanted to ask was about—. You're setting up a specific, or have set up a specific, call centre in Llanfairfechan to deal with the police, calls from the police.

[78] **Mr Lee:** Yes.

[79] **Angela Burns:** Is that actually a direct result of the festive season or was that—? I wasn't quite clear from the paper whether it was a specific response. Is that because the calls from the police specifically tend to be of a certain type of nature, or what?

[80] **Mr Lee:** So, I talked about the secondary triage team, our team of nurses and paramedics who provide help over the telephone—18. So, we have put four posts up in north Wales. The police are a super-user of ambulance services. The police call the ambulance service 25,000 times a year and we know from test-bed work that we've done that, by putting a clinician in the police control room, we can halve the number of ambulances that we send to the police. That's really important because it means that fewer people go to hospital; it means that we dispatch fewer ambulances—so we've got more ambulances for our amber calls that predominantly need an ambulance—but it also means that police officers can go off and be police officers again, rather than waiting for us to attend to someone with a minor injury or a minor health problem that they've come across in the course of their duties.

[81] It is a piece of work that we're leading in Wales and our intention is to do it with all police forces, but we're starting it in north Wales and that will be live as part of our winter plan. There are some spikes to it. So, obviously, in the night-time economy in the run-up to Christmas and the new year period, the police come across more people with minor injuries during that period, but although we're starting it because it's a good thing to have in our winter plan because it will help, it won't stop at the end of winter—it will be a 365 provision.

[82] **Angela Burns**: I just wanted that clarification. Thank you very much.

[83] **Dai Lloyd**: On this point, Caroline, before we move on to Jayne.

[84] **Caroline Jones**: It's on lost ambulance hours. Is that all right?

[85] **Dai Lloyd**: Where's that now?

[86] **Caroline Jones**: Lost ambulance hours—knowing that there will be an increase this winter of probably 4 per cent, again, as there has been previously, you can't respond then to other calls if the ambulances are outside the hospitals. So, can you please tell me what plan you have for this eventuality, really, to improve the situation, if you like?

[87] **Ms Myhill**: We're not planning this winter on the basis that we don't think there'll be pressure, I think is the first thing to say. So, we know that there will be pressure and we know there'll be pressure for us and there'll be added pressures across the system because that's what happens. I know people say that winter is all year round, but there are certain things that do happen. So, our plan is not predicated on there being no delays because I think that that would be a plan that would fall down very, very quickly. So, we are anticipating that there will be pressure and we are anticipating that hospitals, us, GPs—that we will all have added pressure as a consequence of the winter.

[88] The 4 per cent increase that you mention is about demand, not necessarily hours lost. It's a 4 per cent increase in demand that we are seeing year on year. But we are working very hard, as I said at the beginning, with our health boards to do everything we can to keep the flow of patients through the system. A lot of the examples that Richard has talked about in terms of the clinical desk, triaging people before and reducing 900 ambulances in one month—all of those things will reduce the number of ambulances that we take into hospitals.

[89] We are also working very hard with our staff to make more decisions at scene so that our staff have more confidence to make clinical decisions and not take people to hospital where they don't really need to—not taking people to hospital for just a double check or a look-over. So, everything we're doing is focused on reducing the demand and then we are talking with our health board colleagues at the moment about, in the event that we do

get significant pressure, what we will do to prevent ambulances queuing outside hospitals.

[90] There's a national Welsh Government circular that's been issued at the end of winter, which is quite strict in terms of what you do at certain points of delays in terms of clinical assessment and escalation. We've got our own escalation processes this winter, which are much better than we had last year, and, again, we've got that jointly with the health boards. We are looking at the potential for extra capacity that we can put in, in the event that we've got huge delays outside our hospitals and patients in the community needing care. There is a potential that we will be able to provide some mobile support that can move to areas of greatest pressure. So, we're working that through with the health boards at the moment.

[91] **Dai Lloyd**: Ar y pwynt yna, mae yna gwestiwn gyda Jayne hefyd.

Dai Lloyd: On that point, Jayne has a question.

[92] **Jayne Bryant**: Thank you, Chair. I'd just like to say that I found your paper very helpful, actually, so it was very useful reading through that. I'd like to take us into handover issues now, and I notice in the paper that you say that there's a direct correlation between handover delays, the availability of emergency ambulances, and the risk to patients. With that in mind, I was just wondering what you think the reasons are for such a significant difference between local health boards in these handover times, and are there examples of good practice, like the one in Cwm Taf, perhaps, that we could follow.

[93] **Ms Myhill**: There are differences. Sometimes, the difference is the population and the demand, because our hospitals are different, clearly. So, the University Hospital of Wales will see patients very differently to some of our smaller hospitals. So, the demand profile is definitely different. There is something about approach as well. Cwm Taf is an example that you've used. We have very few delays, if any, if you look at the data, in relation to Cwm Taf. Some of that is about the model that they operate: the direct access to medical wards, which we don't have in all hospitals, means that we can get in and out much more quickly. Some of it is about clinical leadership and leadership in that there's a no tolerance, really, to ambulances waiting—so, they're trying to push us away before we want to go, almost, in some of those areas. That is something that genuinely does really help. But the pressures are different. It's not the same everywhere, but there is good practice and, through the Chief Ambulance Services Commissioner, who

works on behalf of all the health boards, we try to share that. The systems are different; you know, the social care is different in different parts of Wales, the support infrastructure is different in different parts of Wales. Unfortunately, it's not one solution for all but, where we can, we will share that practice. I don't know if you want to add anything to that.

[94] **Mr Lee:** Absolutely. Patients flow through the emergency department into the hospital, into the wards, have some treatment and then flow out of hospital back into the community. So, the more people we can keep in the community, the fewer people we take to hospital, the fewer ambulances there are outside. But, actually, flow within the hospital is probably the difference in the different parts of our system. How quickly can a hospital get, especially, a frail elderly patient back into their home with a homecare package that works? How often do those homecare packages fail and the patient comes back? And the systems within the hospital, as Tracy said—. The more often we can take a patient somewhere other than ED—. In the same way that us sending an ambulance to you in eight minutes is only beneficial to a very small number of patients, a lot of patients that go into the emergency department are seen in the emergency department but their actual treatment is given by other specialisms within the hospital. So, the more often we can bypass the emergency department and take those patents directly to the speciality, the more room there will be in the emergency department, the quicker our ambulances will turn around, and the quicker we can deploy the ambulance to the next call. Sometimes, people imagine the halcyon days of ambulances doing a call and then going back to the ambulance station and sitting watching the telly for a bit and then going out again. It's not like that. Our ambulances go from call to call to call. That's the pressures of the system that our staff work under. So, we need the ambulance availability to make sure patients like those Mrs Morgan referred to get an ambulance as quickly as we would like.

[95] **Dai Lloyd:** Cwestiwn olaf— **Dai Lloyd:** Final question—Rhun. Rhun.

[96] **Rhun ap Iorwerth:** I'll squeeze two questions into one, then. [*Laughter.*]

[97] **Dai Lloyd:** Well, brief answers, then.

[98] **Rhun ap Iorwerth:** Leading on from that, there's real concern in my constituency, the Isle of Anglesey, and among paramedics on Anglesey,

about the amount of time that they're spending away from the island. The consequence of that, of course, is it takes longer when they're away—which is most of the time, it seems—for calls to be responded to on Anglesey from ambulances elsewhere in the north-west of Wales. They spend a lot of their time down on the north-west coast. What is being done to try to address that? What lessons, particularly from Explorer Cwm Taf, perhaps—? Given that much of the time, or a not insignificant amount of time, is spent transferring trauma patients from Ysbyty Gwynedd to Stoke, as the trauma centre, what thought has been given to a dedicated fleet of emergency-transfer, intra-hospital transfer vehicles in order to take off the pressure?

[99] **Ms Myhill:** Just a general comment from me in terms of our ability to respond in Anglesey—we've spent time ourselves there, obviously, and we're back up there in a couple of weeks, working with crews—we recognise the drag, almost, and the challenge that has. The geography is clearly a challenge in terms of distances to travel. But what we've been looking at through our new model is—because, particularly, the red calls are low in number now, we can look at every single one, as Richard has said, and we look down to the lowest level we possibly can. It's really encouraging to see, particularly in Anglesey, that in four of the last five months we have achieved above the target. That is significantly different from where we were. There's no doubt about that. If we were talking a year ago, we'd be having a different conversation, because it was shining out to us that we needed to do something different. So, we have been trying to do that to make sure we look after the local population. That's what our crews want to do; they want to look after their neighbours, they don't want to be stuck somewhere else. But we are doing some work on cross-border flows and maybe, Richard, you could add a bit more about that, particularly into England, which is much more prevalent in north Wales, clearly.

10:15

[100] **Mr Lee:** So, the emergency medical retrieval transfer service—EMERTS—the air ambulance service, which we've been augmenting with doctors, now undertake a number of the critical transfers for neuro and for trauma into England from north Wales, but there are still those that we have to do. Unfortunately, there aren't enough of them to support a dedicated resource. They are a daily occurrence, but there aren't enough of them. When we've looked at the data, it wouldn't keep a dedicated service busy.

[101] The return-to-area arrangements are quite important to us. You know

I talked about equity earlier. It's not right that, if you live in one part of Wales, you get a different service to somewhere else. It might be delivered slightly differently, because localism's important, but the standard should be the same. So, we've got a process now that we were trialling between the borders of ABMU and Hywel Dda, so in the Carmarthen-Swansea corridor and in the south Powys and ABMU corridor, where, if a Powys ambulance has ended up at Morriston because it's taken a heart attack patient there, which is the right thing to do, unless there is a red call or a very high priority amber call outstanding in Swansea when that vehicle becomes available, it'll be sent back to south Powys. That has improved—. Members will have noted the improvement in performance in Hywel Dda and the improvement in the performance in south Powys over recent months. That's down to those arrangements—and the hard work of the staff, but down to those arrangements. So, we will roll those arrangements out now across the winter, across Wales. That will lead to some patients with green emergencies waiting slightly longer for an ambulance, but what it will do is it will allow us to provide equity of cover across what are predominantly rural communities where there will always be a pull of resource out. So, it allows us to maintain a service in a rural area.

[102] **Rhun ap Iorwerth:** Before this winter?

[103] **Mr Lee:** Going on now, so, yes. Yes. Before Christmas.

[104] **Dai Lloyd:** Diolch yn fawr. Tri chwestiwn mewn un yn fanna, rwy'n credu, Rhun, ond dyna fe. Reit. Diolch yn fawr iawn. Mae amser y sesiwn yma wedi dirwyn i ben. A allaf ddiolch i'n tystion am eich tystiolaeth fendigedig y bore yma, mae'n rhaid imi ddweud—tystiolaeth arbennig o dda? Diolch yn fawr i chi am ateb y cwestiynau mor fanwl a mor drylwyr. Felly, i weindio i fyny, diolch swyddogol, felly, i wasanaethau ambiwlans Cymru, i Tracy Myhill, prif weithredwr ac i Richard Lee, cyfarwyddwr gweithrediadau. A allaf hefyd eich hysbysu bydd trawsgrifiad o'r cyfarfod yma'n cael ei anfon atoch

Dai Lloyd: Thank you very much. There were three questions in one, I think, there, Rhun. Thank you very much. This session is now drawing to a close. May I thank our witnesses for your wonderful evidence this morning—excellent evidence? Thank you very much for responding to our questions in such great detail and so thoroughly. So, just to wind up, I'd like to officially thank the Welsh ambulance service, Tracy Myhill, the chief executive, and Richard Lee, the director of operations. May I also inform you that a transcript of this session will be sent to you so you can check it for accuracy? With those few

chi i chi gael ei wirio os bydd angen i wneud yn siŵr ei fod yn ffeithiol gywir. Gyda hynny o eiriau, a allaf eto ddiolch ichi am eich presenoldeb a'ch tystiolaeth? Gallaf ddatgan bydd egwyl fer rŵan i Aelodau gael paned byr o goffi cyn dod nôl yma o fewn saith munud. Diolch yn fawr i chi.

words, may I thank you once again for your attendance and your evidence? I can now state that there will be a brief break for Members to have a coffee before returning in seven minutes' time. Thank you.

[105] **Ms Myhill**: Diolch.

Ms Myhill: Thank you.

Gohiriwyd y cyfarfod rhwng 10:18 a 10:26.
The meeting adjourned between 10:18 and 10:26.

Ymchwiliad i Barodrwydd ar gyfer y Gaeaf 2016-17—Sesiwn Dystiolaeth gyda Choleg Brenhinol yr Ymarferwyr Cyffredinol (RCGP) a'r Gymdeithas Fferyllol Frenhinol (RPS)
Inquiry into Winter Preparedness 2016-17—Evidence Session with the Royal College of General Practitioners (RCGP) and the Royal Pharmaceutical Society (RPS)

[106] **Dai Lloyd**: Diolch yn fawr i chi i gyd a chroeso i'r sesiwn nesaf o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon. Beth sydd gyda ni gerbron ydy eitem 3 ar yr agenda nawr—ymchwiliad i barodrwydd ar gyfer y gaeaf. Rŷm ni wedi bod yn cymryd tystiolaeth eisoes y bore yma gan y gwasanaeth ambiwlans, nawr mae'r sesiwn dystiolaeth yma gyda choleg brenhinol y meddygon teulu a hefyd gyda'r Gymdeithas Fferyllol Frenhinol.

Dai Lloyd: Thank you all very much and welcome to this next session of the Health, Social Care and Sport Committee. Next is item 3 on our agenda, which is our inquiry into winter preparedness. We've already taken evidence this morning from the Welsh ambulance trust, and this session will concentrate on the Royal College of General Practitioners and the Royal Pharmaceutical Society.

[107] Felly, mae pedair yma. A allaf groesawu, felly, Dr Jane Fenton-May a Dr Isolde Shore-Nye o goleg brenhinol y meddygon teulu a hefyd Suzanne Scott-Thomas, cadeirydd

So, we have four witnesses. May I therefore welcome Dr Jane Fenton-May and Dr Isolde Shore-Nye from the Royal College of General Practitioners and also Suzanne Scott-

bwrdd fferylliaeth RPS Cymru, a hefyd Mair Davies, cyfarwyddwr RPS ar gyfer Cymru? Felly, croeso i'r pedair ohonoch.

Thomas, chair of the Royal Pharmaceutical Society Wales, and Mair Davies, RPS director for Wales? So, a very warm welcome to all four of you.

[108] Fel y byddwch chi'n ymwybodol, ymchwiliad i barodrwydd ar gyfer y gaeaf ydy hwn. Rŷm wedi gweld ac wedi darllen eich adroddiadau bendigedig chi—diolch yn fawr iawn ichi ymlaen llaw. Mae yna gwestiynau y mae Aelodau eisiau eu holi, a gyda cymaint â hynny o ragymadrodd, fe awn yn syth i mewn i'r cwestiynau, os yw hynny wrth eich bodd?

As you are aware, this is an inquiry into winter preparedness. We've read your wonderful papers, so thank you in advance for that evidence. There are some questions that Members will want to ask and, with those few words of preamble, we will move immediately to questions, if that suits you.

[109] A allaf i ddechrau, felly, gan ofyn a ydy gwasanaethau gofal cynradd yn barod am y gaeaf? Fe allai hynny fod o ochr y meddygon teulu ac o'r ochr fferyllol. Nid wy'n gwybod pwy sydd eisiau dechrau ateb.

May I start, therefore, by asking whether primary care services are prepared for the winter? We could hear from the GPs and the pharmacists. I don't know who wants to actually kick off.

[110] **Ms Scott-Thomas:** I think pharmacists are in different sectors of the health professions. We have recently, since 2015, had pharmacists working in a new sector, which is across GP clusters, working in GP practices. I think that introduction—the emerging evidence is that they have contributed very positively into that environment and certainly have improved patient care in terms of managing medicines. But more importantly, perhaps, the evidence is starting to emerge of freeing up GP time with increased appointment times and enabling GPs to see the more complex patients, which I think will put the GPs that have them in a better place for the winter pressures. Now, not all clusters have cluster pharmacists, as we call them, and that's their choice, some of them. But I'm also aware that we have about 60 pharmacist posts, full-time equivalent posts, in Wales at the moment, but I think that, in terms of sustainability and increasing that, we perhaps need to look at more workforce planning, because it's starting to emerge now that there are difficulties in recruiting those posts now. I think that we need to look at that for the future sustainability of that model.

[111] **Dai Lloyd:** Grêt, diolch yn fawr am hynny. Nid wy'n gwybod a yw'r meddygon teulu eisiau ychwanegu at hynny. Jane.

Dai Lloyd: Thank you very much for that. I don't know if the GPs have anything to add to that. Jane.

[112] **Dr Fenton-May:** The general practice, as I'm sure the Assembly has heard in several of the Plenaries, is currently under severe pressures already. There is a big recruitment—mostly in the more rural areas in the north and west of Wales, but also even in Cardiff there's difficulty getting doctors.

10:30

[113] So, adding the winter pressures onto the problems is very difficult, because we have the increase in flu and respiratory-type acute diseases, which makes the care of chronic disease patients much more difficult, added to which there's more falls and injuries if the weather's icy or snowy. Sometimes, these patients then can't get the care they need or carers getting to them. Very often, we have patients that are pushed in and out of hospital and they are not ready for discharge, they haven't got the care and the support and they haven't been stabilised, and that increases the workload for general practice. We're already, in the winter, managing these acute respiratory things by nebulising patients in the surgery and also getting patients seen in out-of-hours by GPs.

[114] We need to look at this in a more robust way. Some of the health plans last year said, 'Well, the GPs need to do more work to stop patients going into hospital', but if the GPs are already on their knees, then it is difficult for them to do more work. Alongside looking at some of the problems, we need to make sure that we're getting some robust evidence coming out of how we manage this, so we need to support our academic, general practice and primary care colleagues to do more work to look at the issues around some of this problem.

[115] We've spoken about getting more pharmacists and other care people and we are looking at how we change the way GPs work to free up the actual GP need for the service, but, in fact, there aren't some of these additional people available. As their roles become more complex—when I first started you didn't need to train to be a GP—these people will need to train to become primary care general practice workers. So, the pharmacists and the paramedics are very well trained but they are not—and the nurses—not

necessarily importable from other services into primary care and general practice.

[116] **Dai Lloyd:** Ocê, diolch am hynny. Mi fydd yna gyfle i fynd i mewn i hyd yn oed fwy o fanylder nawr wrth i ni fynd ymlaen drwy'r sesiwn yma. Julie Morgan sydd efo'r cwestiwn nesa, rhif 11. Julie, os wyt ti eisiau mynd amdani, ac wedyn Caroline.

Dai Lloyd: Thank you for that. There will be an opportunity to go into even greater detail now as we proceed through the session. Julie Morgan has the next question. Julie, if you want to take question 11, and then Caroline.

[117] **Julie Morgan:** You did say that there needs to be a more robust approach. How much planning has there been with the local health boards and with the ambulance service in developing plans for this winter now that's coming ahead—have you had any discussions with clear plans?

[118] **Dr Shore-Nye:** What I would like to say is: I'm a GP in Aneurin Bevan health board and, as such, I'm not aware of any discussions with GPs on the ground about 2016-17 winter preparedness.

[119] **Julie Morgan:** Is anyone aware of any discussions on the ground?

[120] **Ms Scott-Thomas:** I think planning is going on and people are looking at how we can do things differently. My day job is in Cwm Taf health board, and so I'm aware that there is work going on to look at how you can support patients to avoid admissions and cope with them better in the community through increased social care and district nursing. An element of that is medicine support as well—so, looking at how patients manage their medicines better in the home, because about 10 per cent of admissions are related to medication use or misuse. I think that is a plan that will be emerging, probably, from January on. So, people are looking at this, but unfortunately—it is all down as well—one of the barriers is recruitment, and the plans may be there on the table but putting them into reality is about getting the right people in the right place at the right time. So, it does come back to this issue around the bureaucracy of recruitment but also, 'Are the people there in Wales?' I know it has been said in other parts of the country that there is perhaps an oversupply of pharmacists, but it's not in Wales. I think it may be in pockets, in perhaps England and the higher-populated areas, but it certainly isn't in Wales. We do have an issue in drawing all healthcare professionals into particularly—Isolde and I were just talking,

Isolde works in the top of the Rhymney and I actually live in Merthyr—we do have an issue in drawing them up into those particularly hard-to-recruit areas. So, the plans may be there, but putting them into fruition can be a problem.

[121] **Julie Morgan:** In terms of the shortage of pharmacists, have you got any figures for that? How many, in terms of Wales?

[122] **Ms Scott-Thomas:** No, and that is one of the issues in terms of workforce planning: we don't know. That is something that we need to commission: better workforce planning and knowing what our baseline is to know how to go forward. So, that is something that we do need to address quite urgently.

[123] **Julie Morgan:** So, it's based on local knowledge.

[124] **Ms Scott-Thomas:** Yes.

[125] **Julie Morgan:** So, you think the plans are on the table, but they're difficult to actually carry out.

[126] **Ms Scott-Thomas:** I'm not saying it's not going to happen—it will happen—but there are some barriers. There is a will to do more, but it is about getting the right people, and I think that's across all disciplines, to be fair.

[127] **Julie Morgan:** Right. Is there a forum where these issues are thrashed out?

[128] **Ms Scott-Thomas:** A national forum, or what?

[129] **Julie Morgan:** The local health board areas, for example.

[130] **Dr Shore-Nye:** What I would say within local health boards, and certainly within the cluster system that has developed, is that we do discuss recruitment workload issues as part of the general health board priorities. I think that was more what you were specifically talking about than specifically about winter preparedness, but it is an issue within health boards and we do liaise with pharmacists within that.

[131] **Ms Davies:** I think there's also an issue—we've got new models of care

emerging, but the professions are still very much in their silos. We talk about multidisciplinary work, but, actually, are we putting it into practice? I don't think we really have the evidence to show that it's rolling out, certainly not across the whole of Wales. New models of care—we've got 716 community pharmacies, for instance. Are we utilising the skills of those pharmacists the way we should be utilising them? There is a scheme that's been evaluated—the common ailment scheme around Choose Pharmacy—but it hasn't been commissioned by all health boards across Wales. Also, if we want public behaviour to change, there needs to be a campaign to change their behaviour. At the moment, the only person they still want to see is the GP. The evidence is there that, yes, if they go, for a minor ailment, to the pharmacies—this has happened without any promotion or campaign—it's saving quite a lot of GP time. So, there needs to be a much more national-systems approach across all professions.

[132] **Julie Morgan**: Is there any evidence of how many people—what percentage—are now actually going to pharmacists rather than GPs for minor ailments? Do we have any evidence about that?

[133] **Ms Scott-Thomas**: The evidence is there for the two pilot schemes that were run in very small localities in Cwm Taf and in north Wales. So, the evidence has been published for that. I haven't got the figures with me. For a very small pilot in very small localities where there wasn't a national campaign, I think it did really well. But, the key to it was the collaborative working with the GP and where there was collaborative planning so that the GPs actively triaged patients who rang up, as well, to the pharmacy—that's when it worked really well. There is a plan to roll out the IT platform across Wales that supports that service, but it's then got to be commissioned by each health board. I think we need a bit more of a national campaign—that that is going to be commissioned by each health board, and that it's underpinned by a national campaign to change people's behaviours and change the patient pathway, perhaps, away from the GPs so that the community pharmacist is more of a first port of call.

[134] **Julie Morgan**: So, we have individual examples of good practice.

[135] **Ms Scott-Thomas**: Yes, we have the evaluation.

[136] **Julie Morgan**: We know what should be done—

[137] **Ms Scott-Thomas**: I'm happy to send that. I haven't got the details

with me.

[138] **Julie Morgan**: —but need a national move. Thank you.

[139] **Dai Lloyd**: Ar y pwynt yma, **Dai Lloyd:** On that point—Angela. Angela nesaf.

[140] **Angela Burns**: Thank you. I just wanted to pick up on a point that you made, Dr Shore-Nye, because we are talking about winter pressures. Whilst I totally appreciate the long-term planning you're talking about, you actually said, if I heard you correctly, in answer to Julie Morgan, that you hadn't been consulted at all about the current winter pressures, and I believe your colleague was also saying that. Could you just explain that? Because our inquiry is about how prepared the NHS is for the current winter pressures that will be coming up in the next four or five months. I have to admit to a slight frisson of concern that you've not been involved in anything.

[141] **Dr Fenton-May:** As the representative of the Royal College of GPs, I think this inquiry has been the first time we have been made aware of somebody looking at winter pressures. As a working GP—I apologise, I am retired now, two years, but I used to work in Butetown—the first thing you'd know that there was some pressure in the hospital was some red alert coming through saying not to admit patients, which is a little bit difficult when you're sitting with somebody who's got severe pneumonia, hasn't got a carer and needs intravenous medication, and you haven't got any district nurses to help support the patient. You have to kind of sit there and say, 'Well, I'm sorry, I can't send you to hospital in this area; maybe we could send you to Newport or somewhere if there's a bed that we can find.' So, it is very difficult. I don't think the GPs—. The clusters potentially could be involved with that; I don't think that that is the prime focus of the clusters. And any money that's coming through the cluster system seems to be really very slow in actually making any difference to most of the practices. The way that the clusters work is very varied across Wales, so that is putting increased inequalities into the system. Those who shout the loudest get the most, and those that just opt out of being involved in the clusters are not getting any support. So, that actually has an impact on patients.

[142] **Dr Shore-Nye**: Yes, I'd agree. Obviously, representing the RCGP, I know that this is the first time we've been specifically asked about winter pressures. I've worked in Aneurin Bevan health board for the last three and a half years, and Dr Fenton-May is very accurate in that the response we seem

to get is that the hospital is under the pressure—but no survey as to how much pressure the practices within the areas may be under. Obviously, I can't comment on whether there are more detailed discussions going on within health boards at a higher managerial level, but certainly, as an independent contractor, we're not specifically surveyed on how we might prepare for increasing winter pressures.

[143] **Angela Burns**: That gives me a degree of concern, Chair, because they are the front door.

[144] **Dai Lloyd**: Duly noted.

[145] Caroline nesaf, ac wedyn Rhun, ac wedyn Lynne.

Caroline next, then Rhun, and then Lynne.

[146] **Caroline Jones**: Diolch, Chair. I was going to ask: have we analysed or taken into account previous data on where the pressure points are likely to be, including the current workforce, the skills and resources, and what action is needed, and indeed being taken, to address any issues that we have? I don't suppose you can answer that if you—.

[147] **Dr Fenton-May**: I don't think we've got the figures that relate to the winter pressures. We have got figures to show that it is very difficult to recruit GPs. The actual numbers of GPs, as was discussed in Plenary, may have increased, but the whole-time equivalent of GPs, which is much more important, has not increased. We do have a lot of GPs now that work part-time for whatever reasons; some of them because they're doing other things in the health board, or working propping up something like the cardiac service or the dermatology services in the hospital, or doing managerial-type jobs. But you could potentially say in the winter you might get those doctors to increase the amount of work they're doing, but there are issues around indemnity and the amount of time that you can work as a GP. That is one of the issues that the college of GPs have brought to the attention of the Assembly—that it costs a huge amount.

[148] I might have decided when I retired, for an example, that I would go on the locum round as a GP, but I'd have to pay my indemnity fees upfront, and they're a few thousand pounds. Do I really want to pay a few thousand pounds out in the hope that, in the winter, I might get asked to go and do a locum because somebody was under pressure, and I have to do all my appraisal and my CPD et cetera, which I'd have to pay for? So, we are losing

GPs at the top end, who are nearing retirement, or getting to retirement, or women, or men as well, who have got other commitments, who just think 'Well, it's just too much of an effort to do that.' We need to do serious things—. I'm straying into workforce issues now, I realise, but we need to do serious things to try and encourage people to work. It's the same for other health professionals—the nurses, the pharmacists, et cetera; they have the same issues.

10:45

[149] **Ms Davies**: If I may, I think you've identified the crux of the matter. We may well have some solutions, but if we're not involved in the planning, we can't offer those solutions.

[150] **Caroline Jones**: I was going to say that communication, here, is obviously the main key—you know, the communication between the health boards, the primary care doctors and so on. There doesn't seem to have been the communication to put together where there are no plans. You said there are no plans for winter preparedness—winter pressure—and that is a cause of concern. I'm wondering if there's been a lack of communication.

[151] **Ms Davies**: The one thing I can say, having been a community pharmacist, and having had my own pharmacies in the past, is that as individual pharmacists, yes, we do prepare for winter pressure, obviously, but we're not part of the plan, which could really make a difference, not only to our practice but to the way patients behave and to the workload on, particularly, GPs.

[152] **Caroline Jones**: How can we improve things for the future?

[153] **Dr Shore-Nye**: Could I just add that, actually, as GP practices, it's exactly the same? In my practice we are preparing for winter pressures. So, it's not that there's no preparation going on.

[154] **Caroline Jones**: No, no, are you planning, though, in isolation—each person having their own little piece—instead of there being an integrated approach, really? Is this what we could improve on? That's what I'm asking.

[155] **Ms Davies**: One of the things that I'd like is that facilitation, be it by Government, or particularly by the health boards, to bring practitioners together.

[156] **Caroline Jones**: To bring everyone together.

[157] **Ms Davies**: It's how you can solve this problem between you.

[158] **Caroline Jones**: Yes, exactly.

[159] **Ms Davies**: We need to be working together, not pulling against each other, and everybody's in isolation at the moment.

[160] **Caroline Jones**: That's why I'm looking at the communication issue here and everyone needs to be in—there needs to be an integrated approach. Thank you.

[161] **Dai Lloyd**: Okay, Jane on this point.

[162] **Jane Bryant**: I just wanted to come back to Dr Fenton-May, if I can. You talked about the workforce—I know that we're straying a little bit into workforce planning here. How are we using GPs before they retire? Are there any programmes in terms of, perhaps, looking at reduced hours before they retire? How are we making sure that we're using all of their experiences before they do actually retire and passing those on to new GPs? Is that effective enough at the moment?

[163] **Dr Fenton-May**: I don't think there's any effective plan. Basically, the majority of GP practices are small businesses, and it's up to the partners in the practice what arrangements they make with the partners who are looking at retirement. It is a complex issue, and, as I said, there are various things, like indemnity, pay and how you employ people, involved in that. Some doctors will have retired from practice and will go on to do more administrative-type jobs, but that isn't what everybody wants to do.

[164] **Jane Bryant**: It just feels that we lose a lot of experience. Once people retire, they retire and it's unfortunately a resource that we've lost. Just quickly on practice nurses, I was just wondering how we're using those in GP surgeries to help and support, particularly when there are winter pressures. Are we effectively using those?

[165] **Dr Fenton-May**: I think that when you've got good practice nurses in the practice, they are being used very effectively, but the problem is that many of the current well-trained practice nurses have learned on the job over

the last 20-odd years. Before that, we didn't really have practice nurses. The new nurses that come from secondary care are not necessarily fit to work and do the very high-skilled jobs that the practice nurses do—they need training. We haven't got adequate training. If you do get somebody like that, you then have to lose them from the day job at the coalface to go off to do training, so you haven't got that session filled to do the work, because they're doing their continuous professional development, so you're down a nurse for the day. So, we need better training programmes for practice nurses as well, and we need to be enabled to attract them into practice. At the moment, they're not being very well attracted into practice, I don't think, because of some of the issues around how they work.

[166] **Jane Bryant:** What do you think about, when nurses do their training, perhaps having a session or time working in a GP practice? Do you think that would be useful?

[167] **Dr Fenton-May:** I think all health professionals should have time spent in general practice during their training. There are issues about how you fund that, because if you're training somebody in your GP practice, whoever it is, it takes you away from dealing with the patients, so you need more people working in the general practice, and so you need to fund that somehow to enable those people to do more work in the practice to do the training.

[168] **Dai Lloyd:** Okay. Suzanne, always cognisant of the fact we are trying to talk about winter pressures, as always.

[169] **Ms Scott-Thomas:** Yes, I think workforce is fundamental, and actually recognising that primary care is a huge part of where healthcare is given, and training has historically been in secondary care. As I said, cluster pharmacists are a new model of working, and it's been recognised that we are now starting to move our pre-registration into an integrated pre-registration for pharmacists. We're starting in north Wales this year as a pilot, where pharmacists will train for a significant time in secondary care, in community pharmacy and in primary care. So, we are trying to provide that sort of portfolio experience so that when they are hopefully to go into primary care, at least they can hit the ground running to some extent. But that will take a little while to filter into the system.

[170] **Dai Lloyd:** Mair.

[171] **Ms Davies:** We were talking about winter pressures, and one of the things that we've identified—. The BMA, to quote them, say in their submission

[172] 'the sheer scale of the annual influenza vaccination campaign, leads to increased pressures on the health service during the winter season.'

[173] Now, we've currently got GPs giving flu vaccinations, we've got some community pharmacists, but actually there's tension between those two professions on who's going to deliver that. I would think that one of the urgent things that needs doing is some sort of facilitation so that those two contractors are pulling together to make sure that the targets are reached, and there is nothing happening there. That is definitely one of the solutions. If we could get those vaccination targets up by using everybody who's available to inject the population, and have access to all the population—you know, that is a solution that nobody's addressing at the moment.

[174] **Dai Lloyd:** There are some complicated answers to that one, but I'll come back to that. Rhun and then Lynne.

[175] **Rhun ap Iorwerth:** Rydw i'n meddwl y byddwn ni eisiau dychweled at y pwynt yna yn benodol ynglŷn â brechiad y ffliw. Rydw i'n eich addo chi ein bod ni fel pwyllgor yn cydymdeimlo yn llwyr â'r pynciau yr ydych chi yn eu codi o ran y pwysau sydd ar eich gwasanaethau chi trwy'r flwyddyn. Ond i ddod yn ôl at y gaeaf a'r pwysau yn y gaeaf, rydw i'n meddwl ein bod ni wedi symud ymlaen o ran yr hyn yr ydym ni'n chwilio amdano fo bore yma yn eich ymateb chi i gwestiynau Caroline Jones—eich bod chi wedi cyfaddef, fel dau grŵp, oes, mae yna bwysau yn y gaeaf. Nid oeddem ni'n siŵr yn gynharach, o bosib, i ba raddau yr oeddech chi'n dweud bod y pwysau yna yn ychwanegol, ond yn yr un ffordd yr oedd y gwasanaeth

Rhun ap Iorwerth: I think we'll want to return to that point specifically regarding the flu vaccine. I promise you that as a committee we sympathise completely with the issues that you're raising in terms of the pressures that are on those services throughout the year. But to come back to the winter and the winter pressures, I think we've moved on in terms of what we we're looking for this morning in your response to Caroline Jones's questions, in that you have admitted, as two groups, that, yes, there is pressure in the winter. We weren't sure earlier, perhaps, to what extent you were saying that that pressure was additional pressure, but in the same way as the ambulance service could tell us earlier today, 'There is specific

ambiwlans yn gallu dweud wrthym ni yn gynharach heddiw, 'Mae yna bwysau penodol yn y maes yma oherwydd afiechydon *respiratory* ac yn y blaen', a allwch chi roi eglurhad i ni o beth yn union sydd yn ychwanegu'r pwysau mwyaf arnoch chi dros fisoedd y gaeaf yn benodol, a hefyd beth ydych chi'n ei wneud fel ymateb i hynny? Hynny ydy, a ydych chi'n gallu, mewn rhyw ffordd, ychwanegu *capacity*? Rydw i'n amau nad ydych chi. A ydych chi'n cyflwyno ffyrdd newydd o weithio? A ydych chi yn clicio i mewn i ryw *mode* gaeaf, mewn rhyw ffordd, a beth ydy'r *mode* hwnnw?

pressure in this field because of respiratory diseases and so forth', can you provide us with an explanation of what exactly is adding to that pressure on you during the winter specifically, and also what you are doing as a response to that? That is, can you in any way add capacity? I suspect you can't. Are you introducing new ways of working? Are you clicking into some winter mode, somehow, and what is that mode?

[176] **Dr Shore-Nye:** Can I answer specifically about whether there are increasing pressures? I can basically give you an example from this week. As you know, I'm a practising GP, and certainly from the end of last week to this week, we have noticed at least a doubling if not a tripling of children with fever, and respiratory illness, for which I think it's perfectly understandable for parents to maybe access their GP service rather than deal with it at home. That's been exceedingly noticeable over this last week, and that is a very large proportion of an increase in winter pressures. Other examples might be of someone with a chronic respiratory illness. You mentioned respiratory pressure on the ambulance service—there are those who are managing very well at home with occasional visits, or are managed by the practice nurse.

[177] We mentioned flu, and I know that that may be a hot topic, but not just influenza, but other respiratory illnesses will mean that the demand of these people with chronic illness increases. That will increase their attendance at general practice and will increase the need for home visiting, which we know takes more of a period out of our time than people coming to see either doctors or other healthcare professionals and actually increases demand on hospital services, discharge planning, and then looks forward towards increasing pressure on social care and then managing those people at home. So, they are definite increases that we see throughout the winter.

[178] **Rhun ap Iorwerth:** And the mode that you click into in order to deal

with that, seeing as you know it's coming?

[179] **Dr Shore-Nye**: It's difficult to explain from a broad point of view because I only know from my own personal practice. The way we manage it would be to have to change the way in which we work, in that these chronic-disease clinics may have less input from medical professionals to make up for the on-the-day or urgent demand that is coming from winter pressures. I suspect that's also what happens in hospital and social care and pharmacies and all other professions.

[180] **Rhun ap Iorwerth**: And what about public-awareness campaigns to try to keep people safely away from your door by perhaps sending them over there?

[181] **Dr Fenton-May**: I'm not really convinced that most of the public-awareness campaigns keep people away. They usually get some awful thing on the thing that there's more of A or B in the community, so they come and knock on your door in more numbers—

[182] **Rhun ap Iorwerth**: But it could be somebody else's door.

[183] **Dr Fenton-May**: Well, they usually come to the GP. There was a campaign that, you know, if you've got a cough for three weeks, you need to see your doctor, and you get lots of people coming with a very mild cough, which was not necessarily significant, saying, 'Well, I had to come because I've had it for three weeks, doctor'. What you don't get are the people who've probably got lung cancer coming in because they've had a cough forever and they don't actually turn up because it's changed in its nature. It's a very complicated thing, but we do need some sort of public health thing. I don't think there's very much now very evident about things like flu jabs and things like that. I think that pharmacists do a lot of advertising of the flu jab. Every time I listen to the radio, it says to go to some pharmacy and pay for your flu jab.

[184] **Rhun ap Iorwerth**: They're not allowed to say that, are they?

[185] **David Lloyd**: Roedd Mair eisiau dod i mewn. **David Lloyd**: Mair wanted to come in.

[186] **Ms Davies**: I think we're using the terminology 'raising awareness', but that's not enough—we need to change behaviour. The principles of changing

behaviour are very different to just raising awareness. I think that if Government are going to do public awareness, they need to say, 'What is the outcome I want?' We need people to change their behaviour. We're talking about the increased pressures in the winter. I don't actually know if dispensing figures are up because in the summer, we've got similar pressures with hay fever et cetera. There's always a pressure, quite frankly, but they do go up in the winter.

[187] The big thing at the moment now is that we're also trying to deal with anti-microbial resistance. So, with a lot of the people we tell to come to us don't actually need an antibiotic and it takes much longer to go through that conversation—and I'm sure it's the same for GPs—than writing a script. So, there are other pressures as well as winter pressures, because when everybody thinks, 'Oh, gosh, I've got a cough, I need an antibiotic', that consultation, to address anti-microbial resistance, takes even longer than the writing of the script.

[188] **Dai Lloyd:** Lynne, the floor is yours.

[189] **Lynne Neagle:** Shall I do my questions as well?

[190] **Dai Lloyd:** Go for everything you want.

[191] **Lynne Neagle:** Okay, marvellous. I just wanted to ask about the minor-ailments scheme first because I do think that's got a lot of potential to ease pressure on GPs, but the roll-out of it does seem to have hit a block really—nothing seems to have happened for a long time on that. Why do you think that is?

[192] **Ms Scott-Thomas:** I think the roll-out is happening. The service is dependent on an IT system called the Choose Pharmacy system. I'm aware that Welsh Government have provided funding to roll that system out and NHS Wales Informatics Service are in the throes of doing that at the moment, so it is being rolled out. When we're rolling IT systems out, as you know, it can take a little time, but areas have been prioritised and health boards have their plans in place to implement the IT system.

11:00

[193] So, the IT system will be rolled out, I think, to 400 community pharmacies of the 715 in this NWIS plan, and I think their timescales are over

the next three years, but don't quote me on that; I may be slightly wrong. So, it is happening, but I'm not sure whether that pace could be increased—that's something that you would have to ask them.

[194] **Lynne Neagle**: So, we won't see any new minor ailment schemes in time for this winter, then.

[195] **Ms Scott-Thomas**: You may see one or two in certain localities. I know, within my own health board, we are looking to put it into the Rhondda by the winter. So, that's our priority area, because of the issues there. So, it is happening. Personally, I would like to see a quicker pace and, certainly, we would like to see that this is regarded as phase 1 of the 400 of 715 and phase 2 is to complete the total number of pharmacies in Wales.

[196] **Dai Lloyd**: Jane.

[197] **Dr Fenton-May**: Can I just remind you that—what you said before—it is important that it is done with the collaboration of the local GPs with the pharmacists? So, it's again talking to each other and collaboration across services, because that is how it has worked best in the areas in the pilot. Because it hasn't worked very well in some of the areas, to be fair.

[198] **Dai Lloyd**: Okay. Lynne.

[199] **Lynne Neagle**: I was going to go on to the flu, if that's okay. The immunisation rates dropped slightly last year under the flu programme, despite more people being eligible for it. Why do you think that is?

[200] **Dr Fenton-May**: My understanding was that the percentage of people fell because there were more elderly people and more people with chronic diseases who should've had the flu jab. So, we were vaccinating the same numbers, but there were more eligible people, so the actual percentages didn't look so good. So we need to just keep flagging this up and the more people who can advertise that flu vaccinations are beneficial is helpful.

[201] We also need to make sure that we get private organisations like the care homes to be vaccinating their people, because we have seen problems in a number of care homes where the carers haven't been able to go in because there's flu in the home, and they have been a little bit reluctant to take that up, because they're private organisations and there's a cost involved. So, we are able to vaccinate carers who are family members and we

can vaccinate people who are volunteers for charities as well. That has been seeing an increase over the years. I think it was only last year or the year before, but the numbers have increased for those groups. But there are lots of groups that need vaccination. Hospitals are a big issue—that the staff are not being vaccinated in the hospital.

[202] Talking about collaboration, there have been some trials in things like respiratory clinics to increase vaccination actually in the respiratory clinic, so, instead of people having to go to the pharmacy or to the GP, if they're recurrently going to see the respiratory nurses, the respiratory nurses might give them the vaccinations, and that's worked quite well up in some areas. But, basically, some of these groups—. Sometimes, we're trying to catch the same patients and the most effective way to vaccinate patients is, when they walk in the door, you say, 'While you're here, I will give you a vaccination'. That is the much most effective way to do it, because there will be some people who dissent, but you've got them there and they don't have to make a special appointment.

[203] **Ms Scott-Thomas**: I think the collaborative approach, and, wherever patients are, you look at every opportunity to give them a flu vaccination—I think that's a principle that we need to use more of. So, whoever has the opportunity to give them a flu vaccination, you use that opportunity and you use it well.

[204] **Lynne Neagle**: You've expressed some frustration in your paper that not all pharmacists are able to give the flu jab. What do you think the barriers to that are and how should we address those?

[205] **Ms Scott-Thomas**: I think it comes back, perhaps, to some sensitivities around GPs, and it's seen, perhaps, as not working in collaboration with their local community pharmacists—not all; I think it is getting less. We need to look at a more collaborative way of working across primary care clusters. We have these clusters now and I think we need to maximise how clusters work. I'm sure Isolde can tell us more about that. Some are at a different maturity to others, but, certainly, it's recognising that they are primary care clusters and using all the available healthcare within that primary care, not just everything coming down to sit with the GP. I think there is a better way of doing things.

[206] **Lynne Neagle**: A lot of people would prefer to go to the pharmacist because it's more convenient with work. I always get mine done at the

pharmacist.

[207] **Ms Scott-Thomas:** I think it is about having more access and appreciating what patients want.

[208] **Ms Davies:** It's outside the realms of the Royal College to speak about our contracts, but one of the big problems that we have is community pharmacists have a contract, GP practices have a contract, and they're pulling against each other and not pulled together.

[209] **Lynne Neagle:** Okay. In the light of that, is there anything more, then, that you think the Welsh Government should be doing this year to increase the uptake of the flu vaccine?

[210] **Ms Scott-Thomas:** I think there are a number of patients who, for whatever reason—and perhaps you can say it's myths around the vaccination—will never have that vaccination. Whether there is something to be explored about dispelling those myths, because I think there is a significant rump of patients, if I can use those words—of the public; they're not just patients—who have this myth around the vaccination, that it actually causes flu. I think there is some work to be done in trying to understand that behaviour and trying to change that behaviour, and then having that more of an open access to the opportunity to have the vaccination wherever it suits the patient.

[211] **Dr Shore-Nye:** Yes. It is community awareness. However, I am aware, living within a community, that there is a lot of advertising, there is a lot of media, there is already—and has been last year—a lot of promotion of the flu vaccine with risk groups, within carers and within healthcare professionals. Certainly, it has to be a collaborative approach, acknowledging the difficulties—and, certainly, the RCGP don't particularly want to get into contractual discussions, but it is to put forward a collaborative approach, and immunising people in a place that is right for them has to be the way forward. For a lot of people that may be a community pharmacy, but, for a very large number, that is still their GP, and that is very often the first place they will contact to ask either whether they're eligible for a flu vaccine or whether they can have their flu vaccine. I think there is a role also to widen that out amongst voluntary agencies and the third sector to promote flu vaccine amongst people who, maybe, don't engage with either community pharmacy or general practitioners, to make people aware that they are eligible for flu vaccines as well—people who may not see the awareness and

promotional campaigns that are evident.

[212] **Dai Lloyd**: Rhun.

[213] **Rhun ap Iorwerth**: Just to hammer the point home further, it may well be that people choose to go to see their GP initially to ask about the flu vaccine, but, in the context of hearing pretty often that general practices are under strain, the high-street pharmacy with a stockpile of flu vaccines and plenty of capacity is not allowed to put a sign up outside saying, 'Come in here for your flu vaccine'. Does that have to change?

[214] **Dr Fenton-May**: I thought that they do, because I've seen the adverts outside in Tesco and Sainsbury's. We're not allowed to advertise, but I have heard adverts on Classic FM for—

[215] **Rhun ap Iorwerth**: For the NHS vaccine, I mean.

[216] **Dr Fenton-May**: Yes, yes.

[217] **Rhun ap Iorwerth**: They can go in and pay for it, yes, absolutely, but they get it for free through their—

[218] **Dr Fenton-May**: No, no, but they have signs saying, 'Ask the pharmacist if you're eligible for an NHS vaccination'.

[219] **Dr Shore-Nye**: Yes. I know Sainsbury's—sorry, I shouldn't mention brands—advertise. [*Laughter*.]

[220] **Dai Lloyd**: It might be worth just delineating the at-risk groups who should be having a flu jab, and also dispelling a couple of those myths that you're on about, like patients who say, 'I always catch flu after I've had the flu jab'. So, let me give you the floor to do that.

[221] **Ms Davies**: I think the one thing about at-risk groups is, even if their condition is stabilised, they will visit a pharmacy once a month—or somebody will visit that pharmacy. So, there's that opportunity. I don't mind where people get their vaccination, quite frankly; I just want to sort out how we do this together to make it work. But, even when they're well, for long-term conditions, particularly respiratory, they will be seen once a month in a pharmacy. So, there is an opportunity there that we need to embrace, and I don't think we probably do to the level we should. I do believe that it should

be Government-led. This should be the NHS in Wales pushing these patients, getting their behaviour to change and making them realise why they need to do this. It shouldn't be seen as a commercial—that pharmacies want to do this because they get money and that's over the GPs. We need to get away from that. We need to be actually thinking about the care of patients—a very different approach.

[222] **Dr Fenton-May**: Can I add there? I think one of the problems is some people who have long-term chronic conditions don't realise they're actually eligible. They say, 'Oh, I'm a diabetic, I'm fit, I'm taking my medication' and whatever it is, and they don't think that they fit into that group of people who have a chronic condition. So, we need to actually spell it out to some of these people that, actually, they are the people who are eligible. So, that is a big problem.

[223] **Dai Lloyd**: Unrhyw gwestiynau eraill cyn i fi ddod â'r sesiwn yma i ben? Na, pawb yn hapus. Felly, a gaf i gyhoeddi bod y sesiwn yma ar ben? A allaf i ddiolch yn fawr iawn i'r pedair ohonoch chi am eich tystiolaeth a hefyd am y papurau ysgrifenedig y gwnaethoch chi eu cyflwyno ymlaen llaw? Diolch yn fawr am rheini i gyd. A allaf i jest gyhoeddi y bydd yna drawsgrifiad o'r cyfarfod yma'n cael ei anfon atoch chi i gael ei wirio i wneud yn siŵr ei fod o'n ffeithiol gywir? Wedyn, gyda hynny o ddiolch, a gaf i ddiolch yn fawr iawn i'r pedair ohonoch chi? Cawn ni doriad bach am y tro a dod nôl mewn 10 munud. Diolch yn fawr i'r Aelodau.

Dai Lloyd: Any other questions before I bring the session to close? No, everybody's content. May I announce, therefore, that this session is now closed? May I thank the four of you for your evidence and for the written papers that you submitted beforehand? Thank you very much for all of that. Can I just announce that there will be a transcript of this meeting sent to you for checking, to make sure that it's factually correct? Therefore, with that, may I thank you very much? We'll have a short break now and return in 10 minutes. Thank you to the Members.

Gohiriwyd y cyfarfod rhwng 11:11 a 11:22.
The meeting adjourned between 11:11 and 11:22.

Ymchwiliad i Barodrwydd ar gyfer y Gaeaf 2016-17—Sesiwn Dystiolaeth gyda Choleg Brenhinol y Seiciatryddion a Choleg Brenhinol Pediatreg ac Iechyd Plant

Inquiry into Winter Preparedness 2016-17—Evidence Session with the Royal College of Psychiatrists and the Royal College of Paediatrics and Child Health

[224] **Dai Lloyd**: Croeso nôl i chi ar ôl toriad diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad, a chroeso i'n tystion diweddaraf ni. A gaf i eich croesawu i'r sesiwn yma ynglŷn â'n hymchwiliad ni i barodrwydd ar gyfer y gaeaf? Dyma sesiwn dystiolaeth gyda Choleg Brenhinol y Seiciatryddion a Choleg Brenhinol Pediatreg ac Iechyd Plant. Ac, felly, o'n blaen, a gaf i groesawu'r Athro Tayyeb Tahir o Goleg Brenhinol y Seiciatryddion—bore da i chi—a hefyd, Dr Mair Parry, o Goleg Brenhinol Pediatreg ac Iechyd Plant? Bore da i chithau hefyd.

Dai Lloyd: Welcome back after the latest break of the Health, Social Care and Sport Committee here in the Assembly, and I welcome our latest witnesses. May I welcome you to this session on our inquiry into winter preparedness? This is an evidence session with the Royal College of Psychiatrists and the Royal College of Paediatrics and Child Health. Therefore, before us, may I welcome Professor Tayyeb Tahir from the Royal College of Psychiatrists—good morning to you—and, also, Dr Mair Parry, from the Royal College of Paediatrics and Child Health? Good morning to you as well.

[225] **Dr Parry**: Bore da.

Dr Parry: Good morning.

[226] **Dai Lloyd**: Nawr, rydym ni wedi darllen eich papurau bendigedig, sydd wedi'u cyflwyno eisoes gerbron, ac felly, yn sylfaenol, awn yn syth i mewn i gwestiynau, os yw hynny'n iawn gyda chi. Dyna beth mae'r tystion eraill wedi cael ac mi wnawn ni drin pawb yr un peth. Felly, mi wnaf i symud ymlaen efo'r cwestiwn cyntaf, a chwestiwn cyffredinol i'r ddwy ochr, a gofyn: a ydy'r Gwasanaeth Iechyd Gwladol yng Nghymru wedi paratoi'n ddigonol,

Dai Lloyd: We have read the wonderful papers that you've submitted already, and therefore, basically, we'll go straight into questions, if that's okay with you. That's what the other witnesses have had and we'll treat everybody in the same way. So, I'll move on with the first question, which is a general question for both sides, and ask you whether the NHS in Wales is adequately prepared, in your view think, for the winter that's about to

fuasech chi'n meddwl, ar gyfer y gaeaf yma sydd ar fin digwydd, o ran rheoli derbyniadau ymysg plant a'r rhai efo problemau iechyd meddwl? Nid wyf i'n gwybod pa un ohonoch sydd eisiau mynd yn gyntaf.

happen, in terms of managing admissions amongst children and those presenting with mental health problems. I don't know who wants to go first.

[227] **Dr Parry**: Shall I start? Okay.

[228] Diolch yn fawr. Hyd yn hyn, rydw i'n meddwl mai'r ateb yn gryno ydy, 'Na, nid ydym ni cweit yn barod'. Rydw i'n meddwl bod yna welliannau wedi'u gwneud yn y gorffennol. Rydym ni o'r coleg iechyd plant a phediatreg yn eithaf siomedig, yn y gwelliannau sydd wedi cael eu hawgrymu yn y gorffennol, nad oes cyfeiriad penodol at blant neu at anghenion plant. Un o'r pethau glywch chi'n aml gennym ni sy'n gweithio efo plant ydy, 'Nid oedolion bach ydy plant, ond plant ydyn nhw'. Mae eu hanghenion nhw'n wahanol. Mae heintiau'n effeithio arnyn nhw'n wahanol. Mae'r triniaethau'n wahanol, a fedrwn ni ddim darparu ar gyfer oedolion a disgwyl medru defnyddio'r un strwythurau i wella plant. Nid ydyw'n mynd i weithio. Felly, rydym ni wedi bod yn eithaf siomedig yn y gorffennol, ac, unwaith eto, nid oes yna lot o sylw i blant yn benodol ac mae'n wardiau ni yn orlawn yn ystod y gaeaf efo heintiau gwahanol mewn plant. Hefyd, nid yn unig bod yna fwy o blant, ond mae'u hanghenion nhw'n wahanol, yn fwy dwys, yn y gaeaf, ac nid ydym ni'n barod am hynny eto.

Thank you very much. To date, I think the succinct answer is, 'No, we're not quite ready'. I do think that improvements have been made in the past. We as the royal college of paediatrics are a little disappointed that the improvements that have been suggested in the past haven't made specific reference to children or the needs of children. One of the things you will often hear from us is that children are not small adults; they are children. Their needs are different. The illnesses affect them in a different way. The treatments are different, and we can't make preparations for adults and expect to use the same structures for children. It simply won't work. So, we've been quite disappointed in the past with that, and once again, there hasn't been a huge amount of attention paid to children specifically and our wards are packed during the winter months with different illnesses among children. Also, not just that there are more children, but their needs are different, more intense, during the winter, and we're not currently prepared for that.

[229] **Dai Lloyd:** Diolch yn fawr. Yr Athro Tahir.

Dai Lloyd: Thank you. Professor Tahir.

[230] **Professor Tahir:** The answer is, perhaps, a 'yes' and 'no'—both [*Laughter.*]

[231] **Dai Lloyd:** That's my sort of answer.

[232] **Professor Tahir:** First of all, thank you for this opportunity, because it gives us an opportunity to bring forward a number of issues that affect people with mental illnesses not just in Wales, but across the UK. We've learnt a lot from evidence that's there across the board. I say 'yes', because, on a positive note, we've had ring-fenced mental health funding; there has been investment in the area where I work. I'm a liaison psychiatrist and I work in general hospital and I have done so for the last 15 or so years in the University Hospital of Wales. We see pressures across the year and not just in wintertime. So, thanks for the investment in liaison psychiatry, but that funding has gone specifically towards emergency medicine and also the interface between people over the age of 65 presenting to the emergency unit. So, there has been a development in old-age liaison services across Wales. As chair of the faculty for liaison psychiatry for the Royal College of Psychiatrists, we have recently approved six or seven posts across Wales So, 'yes', there is an investment, and, 'no', because we need to see the impact of that investment, and it would be important to see how those services are developed in different health boards across Wales.

[233] From the Royal College of Psychiatrists, we don't want to be prescriptive, but then there are certain standards that we would want the services to adhere to and, hence, we'd want them to develop services that are effective for patients in those areas, rather than a model that's good for Betsi but not good for Hywel Dda. So, we want them to look at their own services, but we've got a meeting coming up in December in mid Wales, where we're going to talk about how those standards should be for each service, so we'll be able to report later.

[234] **Dai Lloyd:** Grêt. Mae'r cwestiwn nesaf gyda Caroline Jones.

Dai Lloyd: The next question, Caroline Jones.

[235] **Caroline Jones:** Thank you, Chair. Good morning. The *British Medical Journal* research suggests that the increase in very short-term admissions of children with common infections suggest systematic failure in primary care

and in hospital in the assessment of children with acute illnesses that could be managed in the community. Solving the issue is likely to require restructuring of the way paediatric care is delivered. Is there appropriate and sufficient training across the whole healthcare spectrum to enable staff to respond appropriately to the needs of children and, indeed, people with mental health issues in ensuring that prompt access to assessment by the appropriate practitioners and professionals is available?

[236] **Dr Parry:** Fe wnaf i ateb gan mai fi sy'n gweithio â phlant ac rwy'n fwy cyfarwydd efo'r wybodaeth. Rydych chi'n hollol gywir, ac mae hefyd yn un o'r pethau a ddaeth allan—. Fe wnaeth y coleg *paediatrics* adroddiad y llynedd, 'Why Children Die', ac un o'r pethau mawr a ddaeth allan o'r adroddiad hwnnw yng Nghymru oedd bod yna wahaniaeth anferth o ran marwolaethau a bod yn sâl rhwng ardaloedd tlotaf Cymru ac ardaloedd cyfoethocaf Cymru. Roedd hwnnw'n wahaniaeth mawr, ond y gwahaniaeth arall a ddaeth allan, neu'r mater arall a gafodd ei godi yn yr adroddiad hwnnw oedd bod yna broblem efo asesu plant sydd yn wirioneddol sâl—y cyswllt cyntaf efo rhywun sy'n gweithio i'r gwasanaeth iechyd ac adnabod pa mor ddifrifol sâl yw'r plentyn a'i yrru i mewn. Mae ar fy rhestr i, felly rydw i'n falch eich bod chi wedi gofyn.

Dr Parry: Shall I answer, as I work with children and I'm aware of the information? You're completely right, and this is one of the things that came out—. The paediatrics college produced a report last year, 'Why Children Die', and one of the big issues that came out of that report in Wales was that there was a massive difference as regards deaths and being ill between the deprived areas of Wales and the most advantaged areas. That was a big difference, but one of the other issues that was raised in that report was that there a problem with assessing children who are really ill—that first contact with somebody who works for the NHS and recognising how seriously ill those children are and sending them in. That is on my list, so I'm glad that you asked that question.

[237] Mae'n broblem rydym wedi'i gydnabod ers yn hir iawn, efo plant. Jest i roi tipyn o gefndir i chi, mae'r rhan fwyaf o blant yn mynd yn sâl yn y gaeaf oherwydd bod yna lot o annwyd o gwmpas ac mae yna lot o *viruses*. Rydym ni i gyd yn gwybod, os oes gennym ni blant, eu bod

It's a problem that we've acknowledged for a while with children. Just to provide you with some background, the majority of children become ill during the winter because there's a lot of colds and viruses around. We all know, if we have children, that they can get ill

nhw'n mynd yn sâl yn sydyn iawn a'u bod nhw hefyd yn gwella'n sydyn iawn.

quite quickly but that they also improve quickly.

11:30

[238] Mae'r rhan fwyaf o blant, i ddweud y gwir wrthych chi, lle rydw i'n gweithio—rydw i yma heddiw ar ran y coleg, ond yn fy ngwaith bob dydd rydw i'n ymgynghorydd ym Mangor, yn Ysbyty Gwynedd, felly mae gen i brofiad diweddar iawn o beth sy'n digwydd ar ein wardiau ni—yn ein hadran ni, mae 80 y cant o blant yn mynd adref mewn llai na 24 awr o ddod i mewn i'r ysbyty ac mae canran uchel iawn yn mynd adref mewn llai na chwe awr.

The majority of children, really, where I work—I'm here today on behalf of the college, but in my every day work I'm a consultant in Ysbyty Gwynedd in Bangor, therefore I have recent experience of what's happening on our wards—in our department, 80 per cent of children return home in less than 24 hours of being admitted into hospital and a high percentage go home in less than six hours.

[239] Rydych chi'n hollol gywir—yn achos lot o'r plant sy'n dod un ai i'r syrjeri ac wedyn yn dod i mewn atom ni, neu'n dod i'r adran frys, nid oes wir ddim angen iddyn nhw fod yna. Ond, lle nad ydym ni'n dda iawn yn sortio hyn allan—a dyma pam rydw i'n dweud nad ydym ni cweit yn barod am y gaeaf—ydy nad oes gan y rhieni y wybodaeth na'r hyder i ddweud, 'Na, mae'n sâl, ond os cadwaf i o adref a gwneud hyn a rhoi hwn iddo fe, mi fydd o'n iawn'. Nid oes ganddyn nhw hynny. Felly, rydym ni angen gweithio ar hynny fel gwlad, fel cymuned, fel cymdeithas. Rydym ni angen medru galluogi rhieni i fod yn hyderus, iddyn nhw wybod beth sy'n addas i'w gadw adref.

You're quite right— with a number of the children that either go to the surgery and then come in to us, or go to the A&E department, there's really no need for them to be there. But, where we are not very good in sorting this out—and this is why I'm saying that we're not quite ready for winter—is that parents haven't got the information or the confidence to say, 'No, he's ill, but if I keep him home and do this and give him this, he'll be fine'. They don't have that. So, we need to work on that as a country, as a community, as a society. We need to be able to enable parents to be confident, and to know when it's suitable to keep a child at home.

[240] Rydym ni hefyd angen, o ran

We also need to make sure that

pawb sy'n ymweld â phlant ym myd iechyd—nyrsys a meddygon, allan yn y syrjeri ac yn yr ysbyty—gwneud yn siŵr bod ganddyn nhw hefyd set o sgiliau sy'n ei gwneud hi'n hawdd iddyn nhw fedru asesu, 'Na, os gyrra i hwn i mewn, fe rôn nhw driniaeth am dair neu bedair awr a'i yrru adref. Mi fedraf i roi'r un driniaeth i'r plentyn allan yn y gymuned—adref, hyd yn oed, efallai—a gweld y plentyn eto mewn tair neu bedair awr', a chadw'r plentyn allan o'r ysbyty.

everybody who sees children in the medical world—nurses and doctors, out in the surgeries and in the hospitals—have a set of skills that makes it easy for them to assess, 'No, if I send this child in, they will be treated for three or four hours and then home. I can provide them with the same treatment in the community—even at home, perhaps—and see the child once more in three or four hours', and keep that child out of hospital.

[241] Beth rydym ni'n trio gwneud yw rhoi'r gofal cywir i'r plentyn yn y lle cywir, boed hynny yn yr ysbyty neu adref, neu efallai yn un o'r ysbytai bach sydd gyda ni allan yn y gymuned yng Nghymru—y gofal cywir yn y lle cywir gan y person cywir. Felly, mae angen i'r person cyntaf y mae'r teulu yna'n ei weld fod yn gymwys ac yn hyderus ei fod yn mynd i fedru dweud y gwahaniaeth rhwng y plentyn sydd angen dod i mewn ataf i yn yr ysbyty a'r plentyn sy'n gallu mynd adref efo'i fam, sydd hefyd yn hyderus ac yn gymwys i edrych ar ei ôl. Mae'n beth mawr yma.

What we're trying to do is provide the correct care for the child in the right place, whether that be in hospital or at home, or perhaps in one of the small hospitals that we have in the community in Wales—the right care from the right person and in the right place. The first person that that family will see should be competent and confident that they can tell the difference between a child who needs to come in to me at the hospital and a child who can go home with his or her mother, who is also confident and competent to look after them. That's a very big thing.

[242] Mae'n ddigon hawdd chwerthin, 'O, nid oedden nhw angen mynd—gwneud ffŷs'. Ond, a dweud y gwir wrthych chi, mae'r pethau yma sydd yn ddiangen, sef y tripiau diangen i'r syrjeri ac i'r ysbytai, yn gostus, yn un peth—rydym ni'n dal i orfod staffio'r llefydd i'w gweld

It's easy to say, 'Oh, they didn't need to go to hospital—just making a fuss'. But, to be honest, these unnecessary trips to the surgery and to the hospital are costly, for one thing—we still have to staff these places to see them—and they also cause concern. These families have to

nhw—a, hefyd, maen nhw'n achosi pryder. Mae'r teuluoedd yma'n gorfod cael rhywun i warchod y plant eraill ac yn gorfod dod i mewn—cael car, cael bỳs, cael y bygi ar y bỳs. Maen nhw'n gostus ac maen nhw'n achos pryder. Rydw i'n meddwl bod yna ddyletswydd arnom ni i gymryd pob cyfle y medrwn ni i drio galluogi rhieni i fanejo hyn adref.

get somebody to look after the other children and have to find a way in—get a car, get a bus, get the buggy on the bus. They are costly and they do cause concern. I think there is a duty on us to take every opportunity available to encourage parents to manage this at home.

[243] Achos, os ydyn nhw yn dod i mewn i'r ysbyty ac yn aros mewn dros nos bob tro y mae rhywbeth eithaf bach yn bod ar y plant, dyna wnân nhw y tro nesaf a'r tro ar ôl hynny a'r tro ar ôl hynny, oherwydd maen nhw'n dysgu o'r profiad blaenorol, onid ydyn? Felly, mi rydym ni i gyd fel cymdeithas angen derbyn hyn ac angen gweithio ar sut rydym ni'n mynd i ddelio â'r peth.

Because, if they do come in to hospital and stay overnight every time something small is wrong with the children, that's what they'll do the next time and the time after that, because they learned from their previous experience. So, as a society as a whole, we all need to accept this and need to work on how we're going to deal with it.

[244] **Caroline Jones**: Yes. Thank you.

[245] **Dai Lloyd**: Diolch yn fawr am yr ateb cynhwysfawr yna. Rwy'n meddwl yr oedd yna gwestiwn tebyg gyda Julie, ond efallai bod yr ateb eisoes wedi dod gerbron, gan mor gynhwysfawr oedd—

Dai Lloyd: Thank you for that very comprehensive answer. I think Julie had a similar question, but perhaps you've already answered that, given the comprehensive nature of your response.

[246] **Dr Parry**: Sori, rydw i yn siarad.

Dr Parry: Sorry, I do tend to talk too much.

[247] **Dai Lloyd**: Na, roedd popeth yn effeithlon iawn. Julie.

Dai Lloyd: No, it was very effective and efficient. Julie.

[248] **Julie Morgan**: Yes. My question was really about children and the common reasons that they would need to go into hospital. For example, you've talked about colds and the temperatures at this time of year. Could

you tell us any other general reasons why parents would be looking for help?

[249] **Dr Parry**: Mae yna lot o bethau, a dweud a gwir. Yn y gaeaf, fel arfer, pethau argyfyngus ydy'r broblem—pethau lle mae plant yn mynd yn sâl yn sydyn iawn, nid pethau sy'n gallu dod i'r clinig o fewn tair wythnos i weld meddyg—a phethau lle maen nhw eisiau cael eu gweld heddiw.

Dr Parry: There are a number of things, truth be told. In winter, it's critical issues that tend to be the problem—things where children fall ill very quickly, not things that could go to a clinic in three weeks' time to see a doctor—and things that need to be seen today.

[250] Y ddwy her fawr i ni yn *paediatrics,* buaswn i'n dweud—un y byddwch chi'n gyfarwydd iawn efo, sef ffliw. Mae plant, yn enwedig plant sydd efo cyflyrau tymor hir—nid ydyn nhw'n gallu delio efo ffliw yn yr un ffordd ag y byddai plentyn holliach. Felly, mae ffliw yn broblem fawr i ni.

The two major challenges for us in paediatrics, I would say—one you'll be very familiar with, which is flu. Children, particularly children with long-term chronic conditions—they can't deal with flu in the same way as a healthy child would. So, flu is a major problem for us.

[251] Mae yna gyflwr arall, rhywbeth o'r enw bronciolitis, a fyddai, ynoch chi neu fi, yn achosi annwyd. Ond, mewn babanod i fyny at flwydd, mae'n gallu achosi iddyn nhw fod yn sâl ofnadwy. Mae'n feirws penodol. Mae'n dŵad mewn ton, o'r dwyrain. Rydym ni'n ei weld yn dŵad, ac mae plant yn gallu mynd yn sâl iawn, iawn efo fo. Mae hwn yn faich mawr arnom ni yn ystod y gaeaf, nid oherwydd niferoedd, er bod niferoedd yn broblem, ond oherwydd, o'r plant sy'n gorfod dod mewn i'r ysbyty efo bronciolitis, nid ydyn nhw'n debygol iawn o fod o fewn yr 80 y cant yna sy'n mynd adref o fewn 24 awr. Os ydyn nhw, maen nhw'n debygol iawn o ddod yn ôl. Felly, nid ydym ni'n elwa o'u gyrru nhw adref yn rhy fuan, a dweud y gwir. Maen nhw'n debygol

There is another condition, called bronchiolitis, which, in you or I, would cause a cold. But, in babies up to a year old, it can cause serious problems. It's a very specific virus. It comes in as a wave, from the east. We see it coming, and children can fall very ill with that. This is a great burden on us during the winter months, not because of the numbers, although the numbers are also a problem, but, of the children that have to come into hospital with bronchiolitis, they're not very likely to be in that 80 per cent that will return home within 24 hours. If they do, then they're very likely to come back. So, we don't benefit from sending them home too soon, truth be told. They're likely to be in for a long time, so we need to be able to

o fod i mewn am gyfnod hir, felly rydym angen medru edrych ar eu holau am gyfnod eithaf hir, ond maen nhw hefyd yn fwy tebygol o fod angen gofal arbennig—*high-dependency care*—neu hyd yn oed gofal dwys—*intensive care*—ac mae hynny'n cael effaith ar yr holl ffordd rydym ni'n medru rhedeg y wardiau yma.

look after them for an extended period of time, but they are also more likely to need high-dependency care or even intensive care and that is having an impact on the whole way we're able to run our wards.

[252] Ar bronciolitis, i ddweud y gwir wrthych chi, os oes gennym ni ddau faban sydd angen gofal arbenigol— *high-dependency care*— mae hynny'n meddwl ein bod ni angen dwywaith gymaint o nyrsys i edrych ar eu holau. Rydym yn landio i fyny ar adegau yn gorfod nyrsio'r plant yma ar ward agored, sydd yn effeithio ar y gofal y mae'r nyrsys hynny'n medru rhoi i'r plant eraill, oherwydd mae'r plant yma, wrth reswm, yn gorfod tynnu mwy o'u sylw nhw ac maen nhw angen mwy o nyrsio.

On bronchiolitis, to be honest, if we have two babies who need specialist high-dependency care, then that means that we need twice as many nurses to look after them. We find ourselves, at times, having to nurse these children on an open ward, which impacts upon the care that those nurses can provide to other children, because these children necessarily have to take more of their time and they need more nursing care.

[253] Hefyd, mae yna broblem—mae'n rhaid i ni fod yn ofalus iawn oherwydd mae bronciolitis yn haint sy'n gallu mynd trwy ward fel slecs. Felly, rydym ni'n gorfod bod yn ofalus iawn efo cadw'r plant yma ar wahân, sy'n ei gwneud hi'n anodd i un nyrs nyrsio dau neu fwy ar unwaith, oherwydd yn ddaearyddol, mae'r ffordd mae'r ciwbiclau wedi cael eu rhannu allan ar y ward yn ei gwneud hi'n anodd iawn. Felly, buaswn i'n dweud mai dyna yw'r ddau beth sy'n fwyaf o her i ni—nid y

There's also a problem that we have to be very careful with, because bronchiolitis can go through a ward like wildfire. So, we have to be very careful with keeping these children in isolation, which makes it difficult for one nurse to nurse two or more patients at once, because geographically, the way the cubicles are separated on the ward makes it very difficult for that to happen. So, I would say that those are the two things that are most challenging to us; they are possibly not the most

ddau beth mwyaf cyffredin, efallai, ond dyna ydy'r pethau mwyaf heriol i ni dros y gaeaf.

common issues, but they are the most challenging issues during the winter.

[254] Rwy'n meddwl ein bod ni angen meddwl am niferoedd nyrsys. Rydym angen i'r gwasanaeth iechyd fod yn fwy hyblyg, oherwydd yn yr haf, i ddweud y gwir wrthych chi, nid ydym angen staffio chwe gwely gofal dwys ar ward yn yr ysbyty lle rwy'n gweithio. Ond, yn y gaeaf, mi rydym ni, ac rydym ni angen medru bod yn hyblyg ac yn ystwyth er mwyn newid yn ôl y tymor. Rydym angen hefyd bod yn eithaf gwydn, oherwydd dim jest y gaeaf yma y mae bronciolitis yn broblem; bydd yr un broblem y gaeaf nesaf a'r gaeaf wedyn. Felly, rydym ni angen medru cynnal blwyddyn ar ôl blwyddyn a dim jest rhoi rhywbeth i mewn—nid ydym angen *one hit wonder* fan hyn; rydym angen rhywbeth sydd yn mynd i gynnal a bod yn gynaliadwy dros y blynyddoedd i ddod hefyd.

I do think that we need to think about nurse numbers. We need the health service to be more flexible, because in the summer, we don't need to staff six intensive care beds on a ward in the hospital where I work, but in the winter, we do, and we need that flexibility in order to respond to the season. We also need to be quite robust, because it's not just this winter where bronchiolitis will be a problem; it'll be the same problem next winter and the winter after that. So, we need to maintain this year on year and not just produce something for the short term—we don't need a one hit wonder; we need something that's going to be sustainable over years.

[255] **Dai Lloyd:** Dyna ni.

Dai Lloyd: There we are.

[256] **Julie Morgan:** And as things stand, there are not enough cubicles, for example.

[257] **Dr Parry:** Nid bod yna ddim digon o giwbiclau; nid oes dim digon o nyrsys i staffio'r gofal dwys. Mae yna safonau rydym ni'n gorfod cadw efo nyrsys, ac oes os gennych chi blentyn sydd ar ward agored, er enghraifft, sydd ddim angen gofal arbenigol—ac rwy'n meddwl *high-dependency care*—fedrwch chi gael

Dr Parry: It's not that there aren't enough cubicles, but there aren't enough nurses to staff that intensive care. There are standards that we have to maintain with nurses and if you do have a child who's on an open ward and doesn't need specialist care—and I'm talking about high-dependency—care, then you can have

pedwar plentyn i un nyrs.

four children to one nurse.

[258] Efo plentyn sydd efo bronciolitis, sydd yn aml yn gorfod cael ffordd benodol iawn o roi ocsigen iddyn nhw er mwyn eu cynnal nhw—ac am gyfnod hir o dri, pedwar neu bump diwrnod—rydych chi angen un nyrs i ddau blentyn. Felly, mae'r niferoedd o nyrsys yn gorfod mynd i fyny. Os ydym ni wedyn yn ffactorio i mewn y ffaith bod un plentyn yn y fan hyn a'r llall yn fanna, mae'r nyrs yn treulio amser yn y canol a ddim yn edrych ar ôl y plentyn. Felly, mae eisiau meddwl am sut rydym yn cynllunio ein hysbytai yn ogystal â sut rydym yn staffio ein hysbytai.

With a child with bronchiolitis, who will often need a very specific way of delivering oxygen to sustain them—and that can be over a longer period of three, four or five days—then you need one nurse to every two children. So, the nurse numbers have to increase. If we then factor in the fact that one child is here and the other is elsewhere, then the nurse will spend her time between those two rather than look after the children. So, we have to think about how we plan our hospitals as well as how we staff our hospitals.

[259] **Julie Morgan**: Can I ask one more question very quickly?

[260] **Dai Lloyd**: Go on, Julie.

[261] **Julie Morgan**: In your response to an earlier question, you said that some children do go into hospital unnecessarily for six hours or something and that you were able to do the same treatment without them going into hospital. So, do you tell this to the parents and then they still insist on going to hospital? How does that work?

[262] **Dr Parry**: Rydym yn trio. Mae'n anodd iawn. Mae eisiau newid yr holl feddylfryd, onid oes? Yn anffodus, rydym ni wedi, dros y blynyddoedd, trwy efallai bod yn rhy agored ein breichiau, derbyn pawb i mewn i ysbytai. Rydym wedi dysgu pobl, 'Os nad ydych yn dda, rydych chi angen bod mewn ysbyty.' Nid yw hynny'n wir; nid oedd erioed yn wir. Ond rŵan, efo'r cyfyngiadau sydd arnom

Dr Parry: We do try. It's very difficult. We need to change the whole mindset, don't we? Unfortunately, over the years, through perhaps being too open, in taking everyone into hospitals, we have taught people that if you're not well, you need to be in hospital. That simply isn't the case; it never was the case. But now, given the limitations upon us, we have to respond to that problem. Yes,

ni, mae'n rhaid inni ymateb i hynny. Ydyn, mi rydym ni'n trio dweud wrth y rhieni—. Gyda'r rhan fwyaf o'r rhieni, os ydyn nhw'n hyderus ein bod ni'n gwybod beth yr ydym ni'n ei wneud, medrwn ni gael perthynas efo nhw a medrwn ni ddefnyddio pob math o strwythur i gefnogi hyn: beth rydym ni'n ei alw'n '*safety netting'.* Rydym yn aml yn dweud wrthynt, 'Os yw'n sâl yn y 24 awr nesaf yma, peidiwch â mynd i chwilio am GP na mynd i *casualty*—dewch yn syth i'r ward; ffoniwch ni a dewch yn syth i'r ward.' Rydym yn eu gadael nhw efo pethau fel *open access.* Felly, rydym ni'n trio hyrwyddo'r neges yma nad oes angen bod yn yr ysbyty pan rydych yn sâl, a trio, fel rwy'n dweud, rhoi'r hyder i'r rhieni i fedru dweud—. Mae hynny weithiau'n cynnwys rhoi darn o bapur iddyn nhw efo rhestr yn dweud, 'Dyma'r pethau i edrych allan amdanyn nhw. Os welwch chi un o'r pethau yma, ffoniwch ni'n syth bin.' Weithiau mae o'n dangos iddyn nhw sut i roi meddyginiaethau—y pethau mwyaf amlwg ydy *inhalers* a phethau ar gyfer asthma ac felly. Mae'n anodd eu rhoi nhw i blentyn sydd ddim eisiau eu cymryd nhw. Os ydych chi'n methu ag anadlu, yn oedolyn, ac y mae rhywun yn dod atoch chi efo mwgwd a'i roi ar eich ceg chi, rydych chi'n gwybod, 'Mae'n iawn; nid yw'n neis, ond fyddai'n well os cymera i o.' Fedrwch chi ddim rhesymu, fel yna, efo plentyn dwy oed. Mae rhieni yn ei ffeindio'n anodd—maen nhw o dan bwysau, mae eu plant nhw'n sâl a maen nhw'n poeni. Felly, rydym ni'n we do try and explain to parents—. With most parents, if they are confident that we know what we're doing, then we can have a relationship with them and we use all sorts of structures to support this: what we call 'safety netting'. We often tell them, 'If he's ill in the next 24 hours, then don't go in search of a GP or go to casualty—come straight to the ward; give us a ring and come straight here.' We have things such as open access. So, we do try and promote this message that you don't necessarily need to be in hospital when you're ill and try to give parents the confidence to say—. On occasion, that's a matter of giving them a piece of paper with a list of what to look out for, stating, 'If you experience one of these things, then give us a ring immediately.' Sometimes, it shows them how to administer medicines, such as inhalers for asthma and so on. It's difficult to give them to a child who doesn't want to take them. If you can't breathe as an adult and someone places a mask on your mouth, then you know, 'Well, it's fine; it's not nice, but I'll be better.' But you can't reason like that with a two-year-old and parents find it difficult—they're under pressure, their children are ill and they're concerned. So, we do try and take the opportunities to educate parents and to give them confidence in looking after their children at home, but they need that support.

trio cymryd y cyfleon i'w haddysgu nhw a'u gwneud nhw ychydig bach yn fwy hyderus i edrych ar ôl y plant yn eu cartref, ond maen nhw angen y gefnogaeth.

[263] **David Lloyd:** Lynne sydd â'r cwestiwn nesaf.

Dai Lloyd: Lynne has the next question.

[264] **Lynne Neagle:** Thanks, Chair. I've got a couple of questions. The first was on this issue of the lack of—or, you feel, a shortage of—high-dependency beds and intensive care beds. Your paper says that the same pressures exist in that area with no mitigation. So, I wanted to ask: are there any parts of Wales where they're actually looking at increasing the number of HDU and intensive care beds, or is that generally the pattern across Wales?

[265] **Dr Parry:** Mae'r un patrwm â—. A gaf i jest ei wneud o'n glir—? Nid wastad diffyg gwlâu ydy o, ond diffyg nyrsys i staffio'r gwlâu ydy o. Fe fedrwn ni gael gwlâu gwag, ond fedrwn ni ddim rhoi plentyn ynddyn nhw os nad oes nyrs. Felly mae o'n gyfuniad o'r ddau beth, i ddweud y gwir wrthych chi, nid jest y gwely ei hun. Mi ydym ni, ar bapur yn aml—os na fuasai neb o'r staff yn mynd yn sâl, yn mynd ar gyrsiau, yn cael babis ac yn mynd i ffwrdd, mae'n bosib iawn, ar bapur, ein bod ni'n edrych fel ein bod ni'n gallu staffio. Ond yn y byd go iawn—a dyna lle ydw i'n gweithio—yng nghanol gaeaf, mi ydym ni'n ffonio a ffonio a ffonio yn trio cael mwy o staff i ddod i mewn drwy'r amser. Ac rydym ni'n gwario ffortiwn ar nyrsys banc, ar nyrsys o *agencies* a phethau, a'r un peth efo meddygon. Mae yna brinder meddygon ar bob lefel yn iechyd plant, ac mi ydym ni'n gwario

Dr Parry: It's the same pattern—. Can I just make it clear—? It's not always a lack of beds, it's a lack of nurses to staff those beds. We can have an empty bed, but we can't place a child in it if the nursing staff aren't there. So, it's a combination of both, really. Not just the bed itself. On paper quite often—if none of the staff were ill, or went on courses or had babies, it's possible on paper that we look as if we can staff. But in the real world—and that's where I work—we are, in the middle of winter, phoning and phoning and phoning to try and get more staff in all the time. We spend a fortune on bank nurses, agency nurses and it's the same with doctors. There's a shortage of doctors on every level in child health and we spend a fortune in order to keep things going, rather than playing the game for the long term. What we need to do is to get nurses and doctors ourselves in Wales. It

ffortiwn er mwyn cadw pethau i fynd yn lle chwarae'r gêm hir, fel petai. Beth y mae angen i ni ei wneud, a dweud y gwir, ydy tyfu ein nyrsys ein hunain a thyfu ein meddygon ein hunain yng Nghymru, ac mae hynny'n gorfod dechrau efo plant ysgol. Rydym ni'n gorfod gwneud y swyddi yma'n ddeniadol—eu bod nhw'n gweld pobl bositif yn gwneud y swyddi, yn mwynhau, yn *role models* positif yn ein cymdeithas ni—bod ein hysgolion ni yn ddigon da iddyn nhw gyrraedd y safonau i gael mewn i brifysgol neu goleg nyrsio, a'u bod nhw wedyn yn mwynhau, bod ein colegau ni'n ddeniadol, eu bod nhw eisiau mynd i fan yna yn hytrach nag i rywle arall ac wedyn bod Cymru'n lle da i weithio a'u bod nhw'n aros yma, a'n bod ni'n elwa o'u sgiliau nhw ac o'r buddsoddiad o'u hyfforddi nhw yn y lle cyntaf.

starts with children in school. We need to make these jobs attractive, we need them to see positive role models in our society. We need to ensure that our schools are good enough for the children to get those standards to go into medical school and colleges, and that our colleges are also attractive and that they want to go there rather than elsewhere, and that Wales is a good place to work and that they stay here, and that we benefit from their skills and the investment in them in the first place.

[266] **Lynne Neagle**: Thank you. Your paper also says,

[267] 'It is disappointing that many of the recommendations designed to ease the pressures have not been acted upon and we are not aware of any specific action taken in relation to children.'

[268] Can you pinpoint exactly what the recommendations are that you feel should have been acted on that haven't been?

[269] **Dr Parry**: Un o'r pethau mawr ydy nyrsio plant. Beth rydym ni'n trio ei ddweud ydy: mae yna lot o sôn am yr henoed yn ystod y gaeaf, ac eto mae 20 y cant o'n poblogaeth ni yng Nghymru yn blant o dan 18 oed. Mae plant o dan 18 oed yn cymryd 25 y cant o amser meddygon teulu, felly

Dr Parry: One of the major things is paediatric nursing. What we're trying to say is that there's a great deal of talk about the elderly during the winter months, but 20 per cent of our population in Wales are children under 18. Children under 18 do take 25 per cent of GP time, so they use

maen nhw'n defnyddio mwy ar y gwasanaeth na'r niferoedd o blant, os ydych chi'n dallt beth rydw i'n ei feddwl. Mae plant o dan 18 oed hefyd yn cymryd dros 25 y cant o ymweliadau ag unedau brys yng Nghymru, felly eto, maen nhw'n defnyddio'r gwasanaethau yna yn fwy. Eto, nid oes yna ddim sôn amdanyn nhw fatha rhywbeth gwahanol i'r oedolion. Rŷm ni o hyd yn dweud hyn—dyma beth mae *paediatricians* yn ei ddweud ar draws y wlad: bod plant yn wahanol, mae'r cyflyrau'n wahanol. Mae yna lot o sôn am ffliw yn yr henoed, ond nid oes yna ddim sôn am ffliw mewn plant. Ac eto, mae ffliw yn effeithio ar blant mewn ffordd wahanol ac mae'r triniaethau'n wahanol—yn union yr un peth â bronciolitis. Mae bronciolitis yn broblem anferth i ni bob gaeaf. Chlywch chi ddim sôn amdano fo—dim byd mewn argymhellion parodrwydd gaeaf, ond fe ddylai o fod yna oherwydd mae o mor dymhorol, fel yr oeddwn i'n ei ddweud. Mae'n dŵad mewn ton ddechrau mis Hydref—mae'n dod mewn ton o'r dwyrain ac mae'r ward yn llawn o blant bach yn tagu, a babis bach yn tagu. Felly, mae yna ambell i gyflwr penodol—os nad ydym ni'n ei drafod o'n benodol mewn plant, ni chaiff o ddim ei drin mewn ffordd addas, a dyna ydy fy mhoen i.

more of our resource than the number would suggest, if you understand what I mean. Children under 18 also take more than 25 per cent of visits to A&E in Wales, so again, they're using those services more. But again, there is no mention of them as being different to adults. We're constantly banging on about this—this is what paediatricians are saying across the country: that children are different, the conditions are different. There's a great deal of talk about flu among older people but not among children, and flu affects children in a different way and the treatments are different—exactly the same as bronchiolitis. Bronchiolitis is a huge problem for us every winter but you never see it mentioned in any of the winter preparedness recommendations, but it should be there because it is so seasonal. It comes in a wave at the start of October—it comes in a wave from the east and then the ward is full of babies who are finding it difficult to breathe or choking. So, there are a few specific conditions and if we don't actually discuss it specifically among children then it won't be treated appropriately. That's my concern.

[270] **Dai Lloyd**: Dyna ni. Diolch am hynny. Rhun, efallai ein bod ni'n mynd i sôn am iechyd meddwl am

Dai Lloyd: Thank you for that. Rhun, we're going to talk about mental health.

ychydig bach.

[271] **Rhun ap Iorwerth:** Ie. Fe wna i aros efo plant a phobl ifanc, ond os caf i ofyn i chi pa mor effeithiol ydy'r gwasanaethau ar gyfer plant a phobl ifanc sydd yn dod atoch chi fel achosion brys efo problemau iechyd meddwl, o ran effeithlonrwydd yr asesu a sicrhau bod y gofal iawn ar eu cyfer nhw. A gan eich atgoffa mai edrych yn benodol ar y gaeaf yr ydym ni, a oes yna bwysau penodol yn codi dros gyfnod y gaeaf yn y maes yma?

Rhun ap Iorwerth: I'll stay with children and young people. If I could ask you how effective the services are for children and young people who come to you as emergency cases with mental health problems, in terms of the effectiveness of the assessment and the treatment. And reminding you that we're looking at winter specifically, is there additional pressure in this field in the winter?

[272] **Dr Parry:** Do you want to go first on this?

[273] **Professor Tahir:** It is winter specific, but what we see year round is that one of the major reasons why mental health gets involved with children is self-harm. With the crisis teams and lack of crisis teams and lack of liaison psychiatry teams in children, we have to keep kids waiting for an assessment, and that takes the pressure onto their physical health issues and a bed would be blocked. Hence, there is a need for looking into that area.

11:45

[274] Then there is the other issue that was talked about earlier: first contact matters a lot, and if we do not have the right people, fully trained professionals, assessing kids and their families early on, we're not going to have a good impact later on, and those are the children who'll perhaps graduate into, later on, adults with mental health problems, alcohol/substance misuse, behaviour issues and more serious and enduring mental illnesses. So, that's why first contact matters a lot. I know, for specifics, in certain areas, a lack of crisis teams in CAMHS has led to people being in hospital for 48 hours longer than they should have been, and that is not up to standard.

[275] **Dr Parry:** O ran fy ochr i, yn gweithio ar ward lle mae plant efo pob mathau o gyflyrau yn dod i mewn, mae'n rhaid i mi ddweud

Dr Parry: From my perspective, working on a ward where children with all sorts of conditions come in, I have to say that I am quite content

rwy'n eithaf hapus am rai agweddau o CAMHS. Nid wyf i'n cwyno am bob dim, ylwch, rwy'n hapus am rai pethau. Mi ydym ni yn barod—rydych chi i gyd yn gwybod, rwy'n siŵr—wedi cael mwy o arian i redeg gwasanaethau CAMHS ac rydym ni'n gweld hynny'n barod ar y wardiau, i ddweud y gwir wrthych chi.

about some aspects of CAMHS. I'm not complaining about everything, you see; I'm happy with some things. But, as I'm sure you already know, we have been given more funding to run CAMHS services and we see the impact of that already on the wards, if truth be told.

[276] Ein problem ni fel meddygon sy'n edrych ar ôl plant efo salwch corfforol yn hytrach na meddyliol ydy bod dal trafferth ymateb i anghenion y plant yma sy'n dod i mewn, yn enwedig plant sydd â hunan-anafiadau a phethau. Ar y funud, cyn ein bod ni wedi cael mwy o bres yn yr uned lle rwyf i, ac rwy'n gwybod ei bod hi'n debyg iawn ar draws Cymru—. Mi ydym ni wedi medru, yn sydyn iawn, ehangu'r gwasanaeth CAMHS sydd ar y ward o bum diwrnod yr wythnos i fyny i saith diwrnod, sydd yn grêt. Rwyf wrth fy modd efo hynny, oherwydd yn y gorffennol os oedd plant yn dod i mewn ar nos Wener ac wedi hunan-anafu, roedden nhw i mewn tan ddydd Llun os oedden nhw'n holliach neu beidio. Trwy eu cadw nhw i mewn yn disgwyl am CAMHS, rydym ni'n eu tynnu nhw oddi wrth eu ffrindiau ac oddi wrth eu teuluoedd—rydym ni ond yn gwneud pethau'n waeth. Rydym ni'n gwella dim arnyn nhw drwy eu cadw nhw yn yr ysbyty jest yn disgwyl am rywun penodol. Felly, mae hynny wedi gwneud byd o wahaniaeth, ond mae dal yn broblem. Nid oes digon o bobl wedi eu

Our problem, as doctors looking after children with physical illnesses, rather than mental illnesses, is that there is still some difficulty in responding to the needs of these children who come in, particularly those who are self-harming and so on. Now, before we received the additional funding, in the unit where I work, and I know that the situation is similar across Wales—. We have very suddenly been able to expand the CAMHS services on the ward from five days a week up to seven, which is wonderful. I'm delighted with that, because, in the past, if children had come in on a Friday evening having self-harmed, then they'd be there until Monday, whether they were healthy or not. By keeping them in, waiting for CAMHS, we are taking them away from their friends, their families—we're only making things worse. We're not doing them any good by just keeping them in hospital waiting for a specific individual. So, that's made a world of difference, but it is still a problem. There aren't enough people who are trained in CAMHS; there aren't enough available on Saturdays and

hyfforddi yn CAMHS; nid oes digon ar ddydd Sadwrn a dydd Sul. Nid ydy o'n ddim byd y dyddiau yma, hyd yn oed mewn uned eithaf bach fatha'r un rwy'n gweithio ynddo, i ni gael pump, chwech neu saith o blant ar nos Wener a nos Sadwrn wedi hunan-anafu. Fedr un person ddim gweld gymaint â hynny o blant a gwneud asesiad trylwyr ac addas mewn un diwrnod—mae'n amhosib. Felly, maen nhw dal yn aml yn gorfod disgwyl diwrnod neu ddau yn hirach.

Sundays. It's nothing, even in quite a small unit like the one where I work, for us to have five, six or seven children on a Friday night or a Saturday night to have self-harmed. One person simply can't see that many children and carry out a thorough, appropriate assessment in one day. It's impossible. So, they often have to wait a day or two longer.

[277] O'r holl blant sydd gennym ni, a phobl ifanc, ar y ward—. Efo'r henoed mae yna lot o sôn—ac mae'n gas gen i'r dywediad—am '*bedblocking*'. Maen nhw angen gwely, yn amlwg, achos nid oes unlle arall iddyn nhw fynd. Ond, efo plant, nid ydym ni'n cael trafferthion efo gyrru plant adref fel arfer. Mae'r rhan fwyaf o blant yn dod i mewn efo un neu ddau ofalwr cymwys, i ni fedru eu gyrru nhw adref. Ond efo plant CAMHS a phobl ifanc CAMHS, mae o'n gallu bod yn broblem, oherwydd nid yw'r gwasanaethau arbenigol efo unedau *inpatient* CAMHS—nid oes llawer o'r rheini. Mae'r rheini sydd gennym ni yn llawn dop trwy'r amser, ac rydym ni yn cadw plant am wythnosau maith weithiau ar ward yn disgwyl am lefydd mewn unedau arbenigol os oes ganddyn nhw rywbeth sydd tipyn bach yn fwy arbenigol na fedr ein *psychiatrist* ni ddelio â fo. Rydym ni'n gorfod disgwyl am wythnosau.

Of all the children and young people we have on the ward—. With older people, there's a lot of talk—and I hate this phrase—about 'bedblocking'. They need a bed, obviously, because there's nowhere else for them to go. But with children, we don't have those problems with sending children home, usually. Most children come in with one or two suitable carers, and we can send them home with those carers. But with CAMHS children and young people, it can be a problem, because the specialist services with inpatient units—there aren't too many of those for CAMHS. Those that we have are full to overflowing all the time, and we do keep children for many weeks, occasionally, on wards awaiting places in the specialist units if they have something a little more specialist than our psychiatrist can deal with. We have to wait weeks.

[278] Mae hynny'n amharu—mae'r plant yma a'r bobl ifanc yma'n tueddu i gymryd lot o sylw'r nyrsys. Mae'n amharu ar y gofal rydym ni'n medru ei roi i'r plant eraill, fatha'r plant gofal dwys. Mae lot o bobl ifanc CAMHS yn ofal dwys yn eu hunain. Efallai nad ydyn nhw ar ocsigen neu ar *ventilator*, ond maen nhw angen un i un yn aml, ac mae hynny'n tynnu oddi wrth y gofal fedrwn ni ei roi i'r plant efo heintiau sy'n dod i mewn yn ystod y gaeaf. Felly, dyna sut mae'n effeithio arnom ni. Nid ydy o'n dymhorol yn ei hun, ond oherwydd ei fod o'n eithaf cyson, pan mae pwysau tymhorol eraill yn dod ar ei ben o, nid ydym ni'n gallu manejio.

These children and young people tend to take a great deal of nurse time. It affects the care that we can provide the other children, such as the intensive care children. Many of these CAMHS patients are intensive care themselves. They need one to one; they may not be on oxygen or ventilators, but they do need that care and that actually removes capacity to deal with other children who come in with infections during the winter. That's how it impacts us. It's not seasonal in and of itself, but because it is relatively consistent, when other seasonal pressures come on top of that, we can't manage.

[279] **Rhun ap Iorwerth**: Dyna fo, a dyna oedd fy ail gwestiwn i'n mynd i fod. A fyddech chi'n cytuno â hynny hefyd? Buaswn i hefyd wedi dyfalu na fyddai yna sbeic mawr o ran achosion brys iechyd meddwl yn y gaeaf, ond bod yna bwysau ar y gwasanaeth rydych chi'n gallu ei ddarparu iddyn nhw oherwydd y pwysau mewn rhannau eraill o'r gwasanaeth.

Rhun ap Iorwerth: That was going to be my second question. Would you agree with that as well? I would also have guessed that there isn't a big spike in terms of emergency cases, for many people with mental health problems in the winter, but there's pressure on what you can provide for them because there's pressure on other areas of the service.

[280] **Professor Tahir**: That's absolutely correct. In fact, for mental health, there is a dip in self-harm from November onwards, until about January or February time, and then it peaks again. The rates of self-harm and suicide are higher in spring and summer, and in the elderly it is more towards late summer. So, that's not an issue as far as wintertime is concerned.

[281] **Dai Lloyd**: Diolch am hynny. Jayne, a oeddet ti eisiau gofyn cwestiwn 24?

Dai Lloyd: Thank you for that. Jayne, did you want to ask question 24?

[282] **Jayne Bryant**: Just to follow on from that, I think. Professor Tahir just

mentioned having the right people seeing the people at the moment when they come into the service—having the first contact; sorry—but do you think there's appropriate and sufficient training, particularly when we're talking about dementia and winter pressures, with more people coming in, perhaps through falls? Do you think that's a problem?

[283] **Professor Tahir**: One of the beauties of psychiatry is that we work laterally, not hierarchically. Our senior nurses are very well trained and very much respected. For me, in my team, they are my eyes and ears in a general hospital, but that's where training is concerned. While there's some improvement in the split between registered mental health nurses and general nursing, nurses who are trained in mental health will specifically go on to work—some of them—on old age. Working in a general hospital is a different environment altogether, because there are people with co-morbid, physical and mental health problems, and therefore the parity of esteem between physical and mental health is very important. That's the sort of thing that needs to be part of the training.

[284] At the front end of the hospital, in an emergency unit, there is a lot of pressure on nurses and their time. Dealing with mental health sometimes is not the first thing that comes to mind as far as training is concerned, and that's why there's a need to train general nurses working in general hospital, because sometimes the first point of contact is a general hospital. It's the front end of the hospital rather than a psychiatry clinic, or the GP clinic, and that's where bringing that gap between mental health and physical health closer is very important at training level, not only for the nurses, but for doctors and medical students. There needs to be a much more integrated curriculum for mental health and physical health. In Cardiff University, that change has been made, but still there's a lot of work that needs to be done.

[285] **Jayne Bryant**: I suppose the time for refreshing, or refresher courses, is important as well.

[286] **Professor Tahir**: Yes. It's important to remember that the turnover of staff in emergency units and general hospital, for junior nursing staff, is very rapid. That's why they would come in and get trained and then move on to a different job. Then we need to get the training for the new batch of nurses. That's why it's important that it's an ongoing process. The problem is that there are very few liaison psychiatrists working in general hospital and psychiatrists within the community. Community mental health teams are swamped with work within their catchment areas. As you would know,

psychiatry works in every area in regions. For them to move out of their CMHTs and go and do training for general nurses, there needs to be more investment in getting the training up and running, and a regular turnover of training.

[287] **Dai Lloyd:** Dyna ni. A'r cwestiwn olaf gan Angela.

Dai Lloyd: The final question from Angela.

[288] **Angela Burns:** Professor Tahir, I just wanted to clarify your comment about the winter pressures because, in the paper, it says that:

[289] 'the prevalence of self-harm and suicide attempts and completions decreases prior to Christmas; this trend is reversed immediately after Christmas and should be cause for concern for psychiatric services.'

[290] To me, that sounds like it does have an impact on winter pressures. I just wasn't quite sure that that was what you just said. So, I just wondered if you could clarify that.

[291] **Professor Tahir:** So, research across the world, and not just our own local data, shows very clearly that there is a decrease in admissions and presentations for self-harm in hospitals. Then, after Christmas and the new year, come February time, the rates start increasing again. From our data at the poisons unit in Cardiff, we know very well that, in a year, more than 1,200 patients are admitted to the poisons unit every year. Of those, about a third of them are seen by a psychiatrist or psychiatric nurses. But, you're correct; my reflection on that is that, yes, the rates decrease in wintertime for self-harm, but it does go up occasionally—

[292] **Angela Burns:** Immediately afterwards, which is what it says. Do you have enough data to be able to—? Do you have enough empirical evidence that we can use to persuade Government that this might be an area where we need to reassess our funding levels, or our staffing levels?

[293] **Professor Tahir:** So, like I said earlier, investment has come into liaison psychiatry for the elderly. My team in Cardiff and Vale, apart from a part-time post in Swansea, was the only team for working-age adults for the last 10 or 12 years, and there needs to be investment in those under the age of 65 as well. And, yes, I've got data that, year-on-year, my team sees about 2,500 patients and about 1,000 of them are seen in the emergency unit every year, and this would be 24 hours. There are models that the Royal College of

Psychiatrists has worked on—basic liaison psychiatry, core 24 and a comprehensive 24-hour service—and, yes, there is a lot of data, not only from local services, but also from across the bridge in England that we can use to persuade.

[294] **Angela Burns**: Chair, would it be at all possible to ask Professor Tahir, if you have the time to—. There are two bits of information I particularly would like to understand, if at all possible. First of all, as we know, more elderly people get admitted during the winter period because they get things like influenza, slips and falls, et cetera, and if they have some form of dementia, once they're in through the doors of the hospital, they tend to go over the cliff and become very poorly very quickly and it's very hard to bring them back. So, I wondered if you had anything on that, that you might be able to give us a comment on.

[295] And the second area I wanted to ask about was if you have any comment on, during the winter period, in psychiatric illnesses, whether there's a particular increase. I would imagine—I'm talking off the top of my head here—that, say, something like psychotic illnesses are pretty standard all the time, but I wondered if there might be an increase in depression and anxiety throughout the winter periods, and that that may be an area where we might have to look at trying to support that particular element during the winter. So, anything like that that might be able to help us just to have a better understanding of the splits within mental health.

[296] **Professor Tahir**: I know particularly that Julie Morgan has been to visit the response enhancement assessment and crisis and treatment team.

[297] **Julie Morgan**: I was just going to mention it.

[298] **Professor Tahir**: REACT is more in the community. For dementia sufferers who are in nursing homes, when they come into hospital, it could be for various reasons, for example, a fracture of the neck or femur, or as simple as a urinary tract infection or an upper respiratory tract infection, and they would then develop delirium. It is very well known that after an episode of delirium, the dementia suddenly worsens, and there's plenty of information around that. In Cardiff, we have done a trial on delirium, and the treatment and management of delirium. In 2010, that was published, and we know that the recognition of delirium in general hospitals is not too great, because people who come into a hospital might have hyperactive delirium, and they would get referred to psychiatry services very quickly, but those

who have a hypoactive delirium, they would be pleasantly in a bed—I can tell you a number of such stories—confused, and thought of as depressed, and those are the areas that could be part of training in general hospital.

[299] So, with upper respiratory tract infections in winter, that is an issue. Our REACT team has shown some—. I was on call last week, and there was an elderly lady who had taken an overdose, and if we didn't have the REACT team, perhaps we would have had to bring her into a psychiatric unit, but with the REACT team, we were able to prevent an admission.

12:00

[300] But that's something that happens across the year and not just in the wintertime. For psychiatric illnesses, people who suffer from severe mental illnesses like schizophrenia and bipolar affective disorder, for them, it is very important that they are well supported throughout the year and especially at critical times such as winter. People who have got schizophrenia are particularly at risk of developing physical health problems. People with general physical morbidity, multiple physical morbidity or with long-term conditions like diabetes, heart conditions and arthritis are particularly vulnerable to developing psychiatric illnesses and that's where we need to bring in a lot of resources to help those people.

[301] We've collected data in the University Hospital of Wales for about 600 patients. About 30 per cent of those who come to our out-patient clinics have got a depressive illness in particular. So, yes, there's a lot that can be done for patients with multiple morbidities. Medically unexplained symptoms—and I know, in general practice, that people do see that 30 to 40 per cent of their workload is medically unexplained symptoms—that draws in a lot of resources with multiple investigations and, again, the issue of training is important there, and working with those people to prevent admissions into general hospital for physical investigations is important. Support for the psychological: in my team, to see a psychologist it takes about eight months, and that could take pressure off general hospitals. I've got a part-time cognitive behavioural therapist; if I had a full-time one, from eight months we could reduce the waiting time to four months. That's the nature of psychology services across Wales.

[302] Can I mention some other things, if you'll allow me? Neuropsychiatry; young-onset dementia. They are the stories that are heartbreaking to deal with. I've got a gentleman on a neurosurgical ward who has had bifrontal

surgery, and I'm dreading the time when he's ready to go out into the community. Where is he going to go? He's a young man in his 40s, he would need a lot of care and there aren't enough places, and, unfortunately, I hate to use the word 'bedblocking' myself, but that is how he would be—in hospital where he's inappropriately placed. Someone with neuropsychiatric conditions or someone with young-onset dementia—. Cardiff is the only place where there's a young-onset dementia service and we've got very limited resource with those people in hospital. There is hardly anything in the community to work with them. Those are the ones who are particularly at risk in winter as well.

[303] **Dai Lloyd**: Julie, i orffen. **Dai Lloyd**: Julie, to finish.

[304] **Julie Morgan**: I wanted to raise the REACT scheme, because I was very impressed at the visit, where it was described as the hospital going to the patient in the home and providing a multidisciplinary team, and with really striking numbers about how many people had actually been kept out of being admitted to hospital, because of the intervention of REACT. So, how could we get a scheme like that much more widespread? I think that's the key issue. It seems to be a star scheme and I think it would be wonderful, actually, if people could visit it from this committee. But, how do we spread it out?

[305] **Professor Tahir**: In Birmingham, the first team that was set up was the rapid assessment, interface and discharge team, which is from 16 onwards, across ages. I'm one of the very few people who are trained in adult old-age psychiatry and liaison psychiatry. I think there are about 14 of us in the whole of the UK. There needs to be training in those areas, first of all, as medical leadership, for us to lead teams like that. The REACT team is only specific to old-age psychiatry, so we need to broaden the remit of that and we know that the RAID team in Birmingham has shown that for every pound invested, there is anything between a £4 and £6 saving. That's a model that works with prudent healthcare as well; it works across—. It's not only for crises, but it's also working through the rehab phase and the recovery phase. So, we need resources, we need training and we need to attract colleagues from other areas to come and work in Wales, and one of the areas the Royal College of Psychiatrists is very keen on is recruitment and retention. I have trained three specialist registrars in liaison psychiatry and because of no jobs in Wales, they have gone elsewhere to work. So, we need to set up those services and attract those people to stay in Wales. I came to Wales 22 years ago, and I'm an example—I've not left, despite having offers from other

places, because this is where we can make a difference. We are very fortunate to have health boards, where we can work across physical health and mental health areas. We are fortunate to have this interface with the Welsh Assembly Government, and that is very fortunate. So, the resource is there, the networks can be developed, but we need—

[306] **Julie Morgan:** Personnel.

[307] **Professor Tahir:** We need personnel. We need to keep them in Wales to work in these areas, and especially in west Wales or north Wales. We need to develop those services with a focus on rural psychiatry as well, because some people are quite isolated, especially people with mental illnesses.

[308] **Dai Lloyd:** Ocê. Diolch yn fawr iawn. Dyna ddiwedd sesiwn y bore. A gaf i'ch llongyfarch chi eich dau, yn wir, am gyfoeth y dystiolaeth gerbron, yn ysgrifenedig ac ar lafar? Llongyfarchiadau mawr i chi—er mwyn y record—yr Athro Tayyeb Tahir, Coleg Brenhinol y Seiciatryddion, a hefyd Dr Mair Parry, Coleg Brenhinol Pediatrig ac Iechyd Plant. Diolch i'r ddau ohonoch chi. A allaf i jest cyhoeddi y byddwn ni'n anfon trawsgrifiad o'r cyfarfod yma i chi er mwyn i chi ei wirio fo—ffeithiau yn unig; ni fedrwch chi newid eich meddwl neu eich agweddau ar stwff, ond gallwch ei wirio fo o ran bod yn ffeithiol gywir. Felly, diolch yn fawr i chi. A allaf i gadarnhau, felly, bod sesiwn y bore o'r pwyllgor yma wedi dod i ben? Diolch yn fawr am eich presenoldeb.

Dai Lloyd: Okay. Thank you very much. That brings us to the close of our morning session. May I congratulate you both, certainly, for the wealth of evidence that you've given us, both in written form and orally? Many congratulations for that—for the record—Professor Tayyeb Tahir, from the Royal College of Psychiatrists, and also Dr Mair Parry, from the Royal College of Paediatrics and Child Health. Thank you both very much. May I just announce that we will be sending you a transcript of this meeting so that you can check it for factual issues? You won't be able to change your mind about anything, but you can check it just to make sure it's factually correct. So, thank you very much. May I confirm that this morning's session of the committee has come to an end? Thank you for your presence.

[309] Gohiriwyd y cyfarfod rhwng 12:07 ac 13:04.
The meeting adjourned between 12:07 and 13:04.

Ymchwiliad i Barodrwydd ar gyfer y Gaeaf 2016-17—Sesiwn Dystiolaeth gyda Chymdeithas y Cyfarwyddwyr Gwasanaethau Cymdeithasol

Inquiry into Winter Preparedness 2016-17—Evidence Session with the Association of Directors of Social Services (ADSS)

[310] **Dai Lloyd**: Croeso i chi gyd i sesiwn y prynhawn o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon. Byddwch yn ymwybodol—y nifer sylweddol ohonoch chi sydd wedi bod yn gwylio'r trafodaethau hyn drwy'r dydd—ein bod ran o'r ffordd drwy ymchwiliad i barodrwydd ar gyfer y gaeaf. Rŵan, mae gennym sesiwn dystiolaeth gyda Chymdeithas y Cyfarwyddwyr Gwasanaethau Cymdeithasol. Felly, croeso i Neil Ayling, Llywydd ADSS Cymru, a phrif swyddog gwasanaethau cymdeithasol Cyngor Sir y Fflint, a hefyd Claire Marchant, cyfarwyddwr arweiniol gwasanaethau newydd a phrif swyddog iechyd a gofal cymdeithasol Cyngor Sir Fynwy. Croeso i chi'ch dau i'r pwyllgor.

Dai Lloyd: Welcome to you all to this afternoon session of the Health, Social Care and Sport Committee. You will be aware—the substantial number of you who have been viewing these discussions throughout the day—that we are halfway through an inquiry into winter preparedness. Now, we have an evidence session with the Association of Directors of Social Services. Therefore, welcome to Neil Ayling, president of ADSS Cymru, and chief officer of social services at Flintshire County Council, and also Claire Marchant, lead director of new services and chief officer of social care and health at Monmouthshire County Council. Welcome to both of you to this committee.

[311] Rydym ni wedi darllen y papur gerbron, ac felly fe wnawn eich trin chi fel rydym ni wedi trin pob un o'r tystion eraill heddiw: awn yn syth i mewn i'r cwestiynau. Fel rydych chi'n ymwybodol, ymchwiliad i barodrwydd ar gyfer y gaeaf ydy hwn. Fe wnaf ofyn cwestiwn cyffredinol i ddechrau: a ydy'r gwasanaethau cymdeithasol ledled Cymru wedi paratoi yn ddigonol ar gyfer gaeaf 2016-17?

We have read the paper that's before us, and therefore we'll treat you as we've treated each of the witnesses today: we'll go straight into questions. As you are aware, this is an inquiry into winter preparedness. I'll ask a general question to begin with: are social care services across Wales adequately prepared for winter 2016-17?

[312] **Mr Ayling**: Thank you, Chair. Thank you for the question. As you kindly said, I'm Neil Ayling, the director of social services in Flintshire and president of ADSS Cymru. Can I just initially say we are extremely pleased and honoured to be asked to give evidence to the committee, and clearly we would want to respond positively to that request?

[313] I would say that social services are very prepared across Wales in relation to the pressures of winter, and indeed the pressures throughout the year in relation to hospital interface. I think it is a key priority for social services in relation to that response, both at the hospital interface and in the community. I think we all know that, at times, in the past, there have been periods in the winter when services maybe have had a winter break. Those times are well behind us, certainly in terms of Christmas, in terms of a Christmas break. Services are available throughout the winter period and, indeed, many of our services are 24 hours, seven days a week in relation to supporting people at home in the community.

[314] So, yes, we are prepared. One thing I would say is that, quite clearly, we acknowledge we are a key part in a whole system of provision across services, and we, our independent sector colleagues who work with us, our voluntary sector colleagues, and obviously health, ambulance and other partners are a key part in that provision of service. So, we recognise that we need to play our full part in that provision throughout the winter period—indeed, throughout the year, but particularly during the pressures of winter—and we acknowledge that we need to give thought to preparing for that. I know that Claire and I will do that in our local networks at a regional level, in north Wales for myself and in the county of Flintshire, to actually prepare for that. I can clearly say as much as you would like me to, but it's an introductory question, so I'll maybe keep it quite brief, if that's okay, Chair.

[315] **Dai Lloyd**: Bydd mwy o gwestiynau i ddilyn. Diolch yn fawr am yr ateb cychwynnol yna. Fe gawn ni'r cwestiwn cyntaf gan Lynne Neagle.

Dai Lloyd: There'll be more questions to follow. Thank you very much for that initial response. We'll have the first question from Lynne Neagle.

[316] **Lynne Neagle**: Can I ask what you think the key pressures are, then, that face social services departments in Wales as you're going into this winter period?

[317] **Mr Ayling**: Okay. The key—. I suppose I started off by saying that we are a key part of a whole system of service provision, and I suppose that's a

theme we'll come to throughout our evidence, because it's all about providing the best outcomes for people, and outcomes for people require intervention from different parts of the service—health, voluntary and social care, and indeed other services that local authorities provide, such as housing, quite clearly.

[318] The key pressures for social services is in relation to capacity in some areas. I'm not talking about capacity of professional social workers or people who assess for services; I'm talking about capacity—shortages of domiciliary care provision in some parts of Wales, and in some areas, some specialist areas of care home provision are quite strained, particularly around dementia. You will find that those areas are not as available as we'd like them to be. There are fundamental, long-term issues regarding that that aren't around winter or summer or anything else. They're to do with key issues in terms of priorities for resources, key pressures, key cost pressures for the organisations providing those, and in many ways challenges to the workforce in those providers being able to attract enough good-quality staff to be motivated to work in those areas of the social care sector. So, those are the key pressures that we face.

[319] Quite clearly, I would say that many of the investments that have taken place in Wales of late, particularly around the intermediate care fund, have been hugely important in actually strengthening and reinforcing some of those sectors. So, in a sense, as we provide in our evidence, the use of step-up, step-down beds in care homes, the use of preventative schemes based in people's homes and the use of therapy services to actually help provide greater intense care for those areas is important. But it would be remiss of me not to say that those long-term pressures of resources are there for the sector. I do note from reading the evidence that other colleagues have provided to this committee that there's clear evidence that some of those pressures are evident from colleagues who've submitted evidence—from surgeons to nurses to the voluntary sector. That was notable from reading the evidence across the board, for me. So, that would be an initial response. Claire, would you—?

[320] **Ms Marchant:** Just to echo what Neil has said there, really, good community care services are the bedrock of any whole system. When those services aren't right—when they're not available in the right quality or quantum or in a timely way—that causes issues across the whole system. I think that, as you've seen from other submissions, and as you've seen from our submission, we have concerns about the fragility, particularly, of the

domiciliary care sector.

[321] One of the successes of social care in policy and practice in recent years has been the reduction in the reliance on care home placements, but what that means is that people who are in care homes are very frail. The complexity of need that care homes are managing has increased, and the requirement, then, for a quality and quantity of domiciliary care has really increased. The business models and the ways of commissioning domiciliary care over the years—a task-and-time approach to that—we understand are broken, and we're working, and actively working, to change that. So, I think that that is well understood. We manage, and we manage crises in providers on a daily or weekly basis. We've also been able to assume and subsume that in the whole system and quantum of capacity.

[322] But there are significant issues, really, in terms of the funding of the sector, going forward. We operate in Wales with that £60 cap, in terms of people paying for their community care. That places pressures on us, as commissioners of service, around the sustainability, really, of the funding model. There are some really good examples of starting to do things differently. Within the authority in which I work, in Monmouthshire, we've got the roll-out of something called the Raglan project, which is a relationship-based model of care and support, and we're looking now—and actively working—at how that can be applied to the independent sector and our partners. So, commissioning needs to change quite significantly, really.

[323] Critical to all of this is a point that Neil has already made around the workforce. I know there's a separate inquiry about the workforce that this committee will be undertaking. Recruiting the right quality of staff with the right vocation for care, and being able to really train them and make sure that we're not robbing from one part of the sector for another part of the sector, and working together in an integrated whole-system approach around that, I think, is something that is a real priority for us.

[324] **Lynne Neagle**: Thank you. You referred to resources. Of course, the Welsh Government has, thankfully, protected social services in Wales much more than has been the case in England, and has put in very welcome extra funds this year. How critical will it be, as we go into this budget round, that, in looking to future winters, we continue to have that protection for social services?

[325] **Mr Ayling**: I think it's hugely critical and can't be understated in terms

of its importance. As you say, the experience in England is not good in relation to the erosion of some care services. Claire and I were just discussing a recent report that's come out from the King's Fund just very recently, in the last month, regarding social care in England—I think the word is some 'Home Truths'. What it's saying is that there's been a real erosion in some areas of service—that, actually, you're looking at a very patchy provision and you're looking at provision only for those who actually need it, so most people can't actually access that service. In Wales, we've maintained that priority in terms of social care, and it's absolutely evident.

[326] As Claire has said, the resource pressures for the sector are significant. It's been great that we've had that protection in Wales, and we need that to continue. The cost pressures for the sector, because of reasonably good increases in the living wage and in quality and pensions, are about 5 per cent to 7 per cent a year. So, in a sense, with those increases, we absolutely need the protection in terms of care, and I guess we need to actually have a debate about the choices that we as a nation need to have.

13:15

[327] How much can we pay for a care service which we all can rely on? Because, obviously, the domiciliary care cap, as Claire has said, is something that is valued by many and, clearly, we respect that as an association, but it does mean that additional resource needs to be found somewhere for the system to make it work. And so the protection and the safeguarding of funding for social care is very much paramount.

[328] From reading the evidence presented to this committee, it's quite clear that the shortages are not just in social care. Some of the shortages in primary health and community nursing are key things that we see on a daily basis, and that was reflected in the evidence. So, I wouldn't want to give the impression that it is purely about providing resource for social care, but we are a key part of the whole system in terms of responding to the different parts of people's lives.

[329] I suppose that one thing I would say in finishing is that we all recognise that informal support for carers and for organisations is a key part of what we need to provide as a public service, and actually protecting the services to third sector organisations in a way that they can support people caring for themselves, and actually taking care of their own health and social circumstances, is a key area that we would want to join Welsh Government in

supporting. Thank you.

[330] **Lynne Neagle**: Okay, thank you. If I can just ask two other quick questions—.

[331] **Dai Lloyd**: Go on, then.

[332] **Lynne Neagle**: Your paper refers to the importance of the intermediate care fund and the contribution that that makes to reducing pressures. How satisfied are you that social services departments are getting enough of a say in the use of that money, because I know that my own department was a bit concerned that it was a bit too health-driven?

[333] Shall I ask my other question as well?

[334] **Dai Lloyd**: Crack on. You're on a roll now.

[335] **Lynne Neagle**: In terms of the workforce issues, we've talked this morning about flu vaccination. Of course, it's just as important for domiciliary care workers to have the vaccination. Some of them are in-house and some of them are contracted. What are we doing to actually make sure the workforce is vaccinated as much as possible?

[336] **Mr Ayling**: Around the vaccination point, certainly we have flu vaccination programmes for our in-house staff and for our commissioned staff—the independent sector colleagues that work with us. I don't know—

[337] **Ms Marchant**: Yes, that would be the case across Wales.

[338] **Lynne Neagle**: Okay, good.

[339] **Mr Ayling**: And your first question—

[340] **Lynne Neagle**: About the ICF—whether social services are having enough of a say.

[341] **Mr Ayling**: In my region, we have complete openness in terms of discussing the priorities throughout the ICF in north Wales. And, actually—certainly, from a social services point of view—I have no concerns that we don't get our fair crack of the whip in relation to investment of ICF.

[342] **Ms Marchant:** I'd echo that from a greater Gwent perspective. The way that the ICF policy has been administered is that it's administered through health, but it's got to be agreed through the regional partnership fora, and that works quite well. I guess—at this point, we're three years into the intermediate care fund—it's a plea, really, for it to be put on a sustainable footing going forward. We have some recurring moneys that have come back into year three; there are now new moneys coming out, but those need to be spent by 31 March next financial year. And, obviously, it's very difficult to put in place sustainable solutions if you're looking at recruiting workforce on a short-term basis—you're either taking from your current services or you're looking for people who are willing to take on short-term contracts. So, if we could make a plea that we know what works now—it's all well-evaluated in terms of the development of intermediate care services, for example. What we need to make sure is that we've got the right capacity in those services going forward, and that means sustainable long-term investment.

[343] **Lynne Neagle:** Thank you.

[344] **Dai Lloyd:** Jayne.

[345] **Jayne Bryant:** It's just a small point to come back in on what Lynne has said. Do you have any figures around take-up of staff of the flu vaccine? Do you have any information on that, statistics?

[346] **Mr Ayling:** I don't have to hand, but we can provide those to the committee subsequently.

[347] **Jayne Bryant:** I would just be interested to see what the take-up is and if it's gone up.

[348] **Mr Ayling:** To be honest with you, I think it's probably greater in-house than in the independent sector, and I think we've got a way to go to actually make sure that the take-up in the independent sector is as strong as it is for both local authority and for NHS staff. We're on a journey on that, but certainly we can provide figures subsequent to the committee.

[349] **Dai Lloyd:** Rhun.

[350] **Rhun ap Iorwerth:** Just on the intermediate care fund again, is there any evidence of a focusing of that resource on the winter period in particular, and using it as a means to tackle the spikes that do happen within the health

service over the winter?

[351] **Mr Ayling:** I think the intermediate care fund has been fundamentally important at focusing on the areas that are critical to supporting how the health and social care system works together; how people are effectively supported in the community to prevent them going into hospital unnecessarily, and actually how people are effectively supported in hospital to sort of reach in and actually support them well, so that actually they have good outcomes at home. Because obviously one key thing that we haven't said is it clearly isn't all about speed; it is about doing things the right way, and actually giving people a good outcome when they're at home. It's in no-one's interest if, when they're assessed to leave hospital, they're actually in a care home when they shouldn't be in a care home, or they're in an environment where they're actually reliant on home care when they don't need to be reliant on home care.

[352] I think we have used the investment year round, but I think it's been particularly important to actually strengthen pressure during the winter period. I think the—

[353] **Rhun ap Iorwerth:** How?

[354] **Mr Ayling:** How?

[355] **Rhun ap Iorwerth:** Yes.

[356] **Mr Ayling:** Because, when there's been real pressure on district general hospitals in north Wales, the ICF has fundamentally helped in actually seeking to relieve that pressure. So, for instance, if people are on wards and there isn't a particular care home for them to go to, we actually use ICF funding for step-down beds for them to go and actually have a reablement package. That is probably more—. Your point is: is it particularly around the winter? It is year round, but those pressures in terms of admissions tend to be greater in the winter than in the summer period.

[357] **Rhun ap Iorwerth:** Because what we're interested in, in a way, is seeing how resilient health and social care can be year round, which in some way must include a mechanism for concentrating resource over a particular period of the year because of additional demand. Do you have evidence to show that, yes, we're able to help this many people stay in their homes, and therefore keep this many people out of hospital, over that winter period?

[358] **Mr Ayling:** The demand on social care services is consistent throughout the year. We have spikes and we have peaks throughout the year. There are some spikes in the winter period, but there are actually some spikes in other parts of the year.

[359] **Rhun ap Iorwerth:** But, in an integrated system, you would be doing everything you can to take the pressure off where there is a spike, and that is in the hospital.

[360] **Mr Ayling:** Absolutely.

[361] **Rhun ap Iorwerth:** Are you able to do that?

[362] **Mr Ayling:** We are able to do it, and the services that ICF have supported us to do that, have enabled that. So, I suppose your question is: are we able to react in terms of the—? Because we have excellent relationships at ward level. Having social services staff based in the hospitals is key to actual success, and actually having those relationships build up. We have very good relationships at our level in the sense of actually having those abilities to prioritise services if we actually need to, and we have those regional and sub-regional partnerships to have those discussions about planning for the year ahead, for the season ahead, and for longer periods.

[363] **Rhun ap Iorwerth:** Again, can it be evidenced? Can you show when that is happening—

[364] **Mr Ayling:** We can show evidence the ICF has been effective in terms of actually managing that demand. Absolutely we can.

[365] **Rhun ap Iorwerth:** And if that something that could be shared, obviously, with the committee we would appreciate it.

[366] **Mr Ayling:** Yes.

[367] **Ms Marchant:** I think it's that ability to flex up, and where ICF has been particularly effective, as Neil has said, is those type of services that are at the interface of health and social care. So, the step-up, step-down beds, the in-care facilities, the expansion of those reablement-type services, the—I call them rapid response domiciliary care provision, which tends to be in-house services that can be put in place on a short-term, bridging basis, while the

long-term services—. Where we struggle as a social care system, which isn't particularly related to the ICF question, is around the quantum of capacity that's out there in the core community services. Neil quite rightly picked up the issue of community nursing and primary care in addition to domiciliary care and those services that we commission and provide as social services. Even where we want to try and put more investment into those services, sometimes there is an issue in terms of recruitment of workforce and the ability to get that workforce in quickly. So, there are issues in core that sometimes will mean we experience a delay in a transfer of care from those intermediate services into those core community services.

[368] **Rhun ap Iorwerth**: And, not another question, but just a point: I appreciate that point, and please be honest, as honest as you can be, in terms of where the blockages are to you being able to do more, because that's what we'd like to highlight in this report.

[369] **Mr Ayling**: Just to pick up on that briefly, if I may, Chair, the blockages have been around the availability of direct care, okay? It's not around professional assessment and around actually having those networks to give people—it's around direct care, be it reablement or be it in longer term support. So, in my authority, this winter and longer than that, we've had sessions where we're meeting with health colleagues weekly or twice weekly to actually say who are the people for whom we need to expedite those blockages, and how we can actually build more capacity into the market so that there are provisional domiciliary care agencies in rural area or there's some choice about dementia support in terms of residential care, because some of those shortages are very real. I know you will know of those from your constituency work. We have noticed a real increase in the intensity of those blockages in the last year, undeniably so.

[370] **Rhun ap Iorwerth**: Can you expand on that, because that's a key point?

[371] **Mr Ayling**: Yes, well, to some degree it relates to what I was saying earlier about the whole system and it relates to what we said about workforce. In some areas, domiciliary care agencies, including local authority, have not been able to attract staff to work and provide care. My authority, Flintshire, is a border authority, and there are alternatives for people in terms of work. I suppose there's a real challenge for all public bodies, I believe, to actually up our game in terms of the prominence of the social care economy and the social care sector. How important is it for us? Clearly, we're all deeply committed to all sorts of industries in our

communities, and many of those are in Wales, but the social care sector—we don't know the exact figures, but, certainly, looking at authorities, I'm sure there are 30,000 people working in the social care sector in Wales. We need to protect, build on and, actually, support that sector in the same way that we do other sectors.

[372] **Rhun ap Iorwerth**: Thank you.

[373] **Dai Lloyd**: Julie.

[374] **Julie Morgan**: Just following up that point for a moment, are many of the workers in the social care sector from other parts of the EU? Have you got any analysis of that?

[375] **Mr Ayling**: There are surveys in relation to the social care workforce that give some breakdown in terms of nationality, and we can seek to provide that. I think we know that the care home sector has a significant number of people from the EU and from further afield in relation to that, and the domiciliary care sector, similarly. There are many people who come from the EU who work in that. I think, without getting into political water that I shouldn't get into as an officer—

[376] **Julie Morgan**: I just wanted facts—

[377] **Mr Ayling**: No, okay. Definitely a proportion of them do come. I don't know if you've got any specifics, Claire.

[378] **Ms Marchant**: I don't know the specifics, but, certainly, when we look at the workforce, particularly within the independent sector rather than the directly employed within the authority sector, yes, there'll be significant proportions within care homes and domiciliary care providers.

[379] **Julie Morgan**: Thank you. The other question I'd wanted to ask, which was to pick up on something you were saying earlier, both of you referred to this £60 cap on the domiciliary, at-home fees. It sounded as if, when you both said it, it was a problem, and I just wondered if you could expand on what you were saying about it, really.

[380] **Mr Ayling**: I think I was saying that, in relation to my authority, the £60 cap means that there's less money to actually fund the overall system. The additional demand that's created by the £60 cap—there's additional

demand for homecare services in my authority as a result of the domiciliary care cap. We accept that we had support from Welsh Government to support local authorities in terms of transition, and I was certainly there and involved in those discussions. But I think, for my authority, it means that, probably, there's over £1 million per year, which is having to be funded elsewhere within the public sector to provide the same level of domiciliary care.

13:30

[381] I suppose that's the problem about it; it's certainly not a bad thing in terms of limiting the amount that people pay, but, clearly, the fact that the people pay that maximum regardless of their income means that there's potentially lost income coming into the social care system. So, I guess that's what I was meaning in terms of saying it presented challenges to us. When we're looking at ways of funding health and social care when, obviously, resources are tight, that is one thing that we should consider is what we were suggesting, I think.

[382] **Ms Marchant:** Yes. It's certainly not making any points about whether that's a really positive policy to be in place in terms of the impact on the people who've benefited from it, but it is a reality that people who were accessing and paying for their own care outside of coming through the local authority prior to the cap coming in, are now coming in via the local authority and, along with others, are benefiting from that cap being in place. One of the points—

[383] **Julie Morgan:** So, are you saying that the imposition of the cap meant that more people started to claim services?

[384] **Mr Ayling:** Yes, because some people would've made their own arrangements previously, and when there's an actual cap on domiciliary care, they actually refer for services. So, yes.

[385] **Julie Morgan:** I suppose you could look at that to say that those are people who needed services and who were only able to have them because there was a cap.

[386] **Mr Ayling:** You could.

[387] **Julie Morgan:** Sorry, I interrupted you.

[388] **Ms Marchant**: Just to make a point, which is, I suppose, allied to that. One of the points I made is I think it is a huge success of policy and practice that people are now being supported in their own homes, who, five or ten years ago, would've been in a care home setting. They're being supported in their own homes with the cap in place, and the cost of the equivalent and what they would've been paying for the equivalent care home placement was obviously far higher than what they're now contributing within the community. Doing the right thing, that's what we're there to do as practitioners and directors of social services—the right thing for the person. That's the frame through which we must see everything. But we also have to be cognisant of the financial implications of that and the level of support, which, for some people who are having to remain within their own homes, is very significantly more than the cost of what the equivalent care home placement would've been.

[389] **Dai Lloyd**: Okay. Caroline Jones.

[390] **Caroline Jones**: Thank you, Chair. Communication and planning are of paramount importance in the management of unscheduled care pressures. Can you tell me, please, how effective the local authorities have been in both communicating and planning with local health boards?

[391] **Mr Ayling**: We have a range of networks for doing that. I meet with my equivalent in health, the area director in Betsi Cadwaladr university health board on a regular basis and our teams also meet. The communication, as I said, on the front line, is hugely impressive; our managers work in hospitals and actually provide that communication. Obviously, on a senior level, I, the chief executive, the leader of the council and the cabinet member of the council meet regularly with colleagues in BCU to actually discuss those issues.

[392] Obviously, we are all doing that, in a way, to actually ensure that communication is working well and to ensure that, if there are any barriers or any things that we can solve internally within our organisations to actually expedite problems and ensure that those linkages are effective, we do it. So, I would say that they're very positive, and I think, obviously, the establishment of the Part 9 partnership boards under the social service and well-being Act is a further strengthening of that, and that is growing and developing in terms of maturity and will provide a further emphasis. Of course, we shouldn't forget that the public service boards are still a key part of that communication as well, Certainly, health, social care and well-being is

of fundamental importance within the public service board that I work in in Flintshire and I know from colleagues that that's the case in other authorities across Wales.

[393] **Ms Marchant:** Just to echo that, really, in the authority I work in, on the ground, we've got integrated teams, so we've got integrated health and social care teams, which is part of the same service; they assess people once, they care-plan once and that reflects in the way that they work with the hospitals locally. At senior levels, one of the things, in addition to all those formal partnership structures that Neil has described, I think, which has really improved over the last number of years, is the fact that we just expedite things daily. So, if it's running hot within the hospitals, we know about it from the chief operating officer or their equivalents. At the same time as they're managing the problem, we're in there trying to work with them and to solve the problem with them. So, I think that ability to expedite and to escalate quickly is something that has really improved in recent years.

[394] **Caroline Jones:** Yes. So, the communication is there. What about the planning for the unscheduled pressures? Hotspots and—.

[395] **Ms Marchant:** That happens all the time. We've got our formal winter plans. We've submitted those to Welsh Government. We've been part of all those sorts of planning sessions. I think the important bit, looking forward, is the intelligence across our health and social care communities, about where our risk issues are, where our capacity points are—it might be around community nursing, it might be around primary care, it might be around domiciliary care and the care home sector in parts of, with us, the greater Gwent area—and then using the resources that come in. So, there is the new intermediate care funding, for example, that we've had for this year to try and strategically put in place solutions together, which makes sense to all of us. So, that is there, in the planning sense, and it's really supported by the statutory partnership arrangements.

[396] **Caroline Jones:** Thank you.

[397] **Mr Ayling:** Again, it's at different levels. We have a regional plan in relation to these issues across north Wales. In Flintshire, one of the two key priorities on the public service board is in relation to health and social care and those workers so that there's a plan that lays out that in the long term. That responds to winter pressures, amongst other issues. Clearly, some of these issues we've talked about, about the pressures in the sector and the

need to actually respond to those are key elements of those plans.

[398] **Caroline Jones**: Thank you.

[399] **Dai Lloyd**: Lynne, you had a question.

[400] **Lynne Neagle**: It was just to return to this issue of the cap, because I think it is important in terms of the pressures that you've highlighted. Now, that the transitional funding has ended, the Welsh Government would say, 'Well, the money is going into the rate support grant'. Is it your contention that that isn't being properly compensated for in the rate support grant, or have we got a problem with local authorities not passing that money on to social services departments?

[401] **Mr Ayling**: No. The local authorities have passed it on to social service departments, so that money is in my authority, but there's been additional demand on top of that in relation to the implication of the cap, which we've described, which is over and above the amount that came in from Welsh Government around the transition.

[402] **Lynne Neagle**: It was an unfunded pressure, then.

[403] **Mr Ayling**: Yes.

[404] **Lynne Neagle**: Okay, thank you.

[405] **Dai Lloyd**: A oes yna unrhyw gwestiwn arall cyn i mi ofyn yr un olaf i gloi? A allaf i jest gofyn yn gyffredinol—? Mae yna ddeddf newydd yn y maes, wrth gwrs—Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014. A allech chi jest olrheinio effaith y ddeddf honno ar y galw am wasanaethau a'r ffordd o ddiwallu anghenion, yn enwedig yn ystod y gaeaf?

Dai Lloyd: Are there any further questions before I ask the final question? Could I ask, generally—? There is new legislation in this area—the Social Services and Well-being (Wales) Act 2014. Can you just tell us the impact that that Act has had in terms of the demand for services and meeting needs, particularly during the winter months?

[406] **Mr Ayling**: The Social Services and Well-being (Wales) Act has—. One of the fundamental changes around it was actually changing the relationship with people that use services, with much more control and much more

independence in the hands of people that use services rather than being people that are passive recipients of services. So, quite clearly, one of the implications of the Act is that our services have followed that philosophy. So, for instance, our initial access services, which we in north Wales call single point of access, or SPOA, actually run along those lines. We actually have an IT service called Dewis Cymru, which I hope you've heard of, which is a way that people themselves can actually find information about the services in their area and respond to those themselves in terms of information about different providers, how they might get in touch with the third sector. Single-point-of-access services seek to actually find out what the issue is that the person themselves perceives, rather than traditional approaches like, 'Do you require assistance with activities of daily living?', and respond to that issue. Those approaches, where you've got local authority, health and third sector colleagues working alongside each other, have been really quite transformational in terms of actually changing our service offer at the front door to try and actually manage some of the services that are actually presenting on us. If you're asking me, 'Has that meant that we've freed up capacity?', I would say, 'No, it has not', because, actually, if you look at the demand on services and the demographic increases that we all are actually facing in Wales, it means that that is a way of actually managing the demand that will be there anyway. But, certainly, it's had that positive impact in terms of quality, and, if done well, quite clearly, it's a very resource-effective way, as well as a good-quality way, to respond to people, where they keep control and they actually are enabled and supported to find their own solutions.

[407] **Ms Marchant:** I echo all of that. Fundamental to the social services and well-being Act are the duties around well-being. One of the points we really wanted to get across, alongside all the talk about service solutions, is the absolute importance of addressing loneliness and social isolation and putting in place—and the ICF has been fundamental in this as well—those sort of community connections and local area co-ordination approaches, which the third sector is so important in providing. The investment in those sorts of approaches, which are fundamental to the Act, is enabling us to manage demand, if I can put it that way, far more effectively than we otherwise would. People might still need an element of care and support, but their social needs, and their needs for continued connection, are being met as well. The evidence is clearly there that loneliness and social isolation is a bigger scourge and a bigger problem for people and cause as many pressures on health services as obesity, for example. So, it is absolutely fundamental, and that's completely there within the Act.

[408] It's still early days, in terms of the Act itself, and a lot of the changes around trying to be more outcome focused in assessments and asking those 'what matters' questions—some of those happened in advance and those changes, in practice, will continue to progress. Then, obviously, the Act gives us duties as well about promoting alternative models of provision, and when we're talking about those radical and different solutions for things like domiciliary care, that may take us to different places over time. It's important that we're putting the effort into those commissioning responsibilities—obviously, part 9 we've talked about—and absolutely embedding partnership and integrated working. So, it's early days in terms of the Act itself, but it's in the right direction, I think, in terms of the approaches we're trying to take.

[409] **Dai Lloyd**: Ocê. Pawb yn hapus? Pawb yn hapus. Rhyfeddol. Diolch yn fawr iawn ichi am eich tystiolaeth ac am eich presenoldeb—cyflwyniad graenus iawn oddi wrth y ddau ohonoch chi. Jest i gadarnhau, ar gyfer y record, diolch yn fawr i Neil Ayling, llywydd ADSS Cymru a phrif swyddog gwasanaethau cymdeithasol Cyngor Sir y Fflint, a hefyd i Claire Marchant, cyfarwyddwr arweiniol gwasanaethau newydd a phrif swyddog iechyd a gofal cymdeithasol Cyngor Sir Fynwy. Diolch yn fawr iawn i chi'ch dau. Fe allaf gadarnhau hefyd y byddwn ni'n anfon trawsgrifiad o'r cyfarfod yma atoch chi er mwyn ichi ei wirio i wneud yn siŵr ei fod yn ffeithiol gywir. Hynny yw, ni allwch newid eich meddwl ynglŷn â rhywbeth rydych wedi ei ddweud, ond gwnewch yn siŵr ei fod yn ffeithiol gywir gogyfer â'r cofnodion. Diolch yn fawr iawn i chi.

Dai Lloyd: Okay. Everybody content? Everybody is content. Amazing. Thank you very much for your evidence and your attendance—a very polished performance from both of you. Just to confirm, for the record, thank you to Neil Ayling, president of ADSS Cymru and chief officer of social services at Flintshire County Council, and Claire Marchant, lead director of new services and chief officer of social care and health at Monmouthshire County Council. Thank you very much to you both. I'll confirm as well that we'll be sending a transcript of this meeting to you for you to check the factual accuracy. You can't change your mind about something that you've said, but you can make sure that it is factually correct for the record. Thank you.

[410] **Mr Ayling**: Thank you very much.

[411] **Ms Marchant**: Thank you. Diolch.

13:43

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[412] **Dai Lloyd:** Rŵan, o dan eitem 6, rwy'n cynnig, o dan Reol Sefydlog 17.42, i benderfynu gwahardd y cyhoedd o weddill y cyfarfod a mynd â'r trafodaethau i fod yn breifat. Diolch yn fawr.

Dai Lloyd: Now, under item 6, I propose, under Standing Order 17.42, to resolve to exclude the public from the remainder of the meeting and for proceedings to be private. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 14:43.
The public part of the meeting ended at 14:43.