Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee

Dydd Iau, 10 Ionawr 2013
Thursday, 10 January 2013

Cynnwys
Contents

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

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.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mick Antoniw	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Mike Hedges	Llafur (yn dirprwyo ar ran Mick Antoniw) Labour (substitute for Mick Antoniw)
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Julie Morgan	Llafur (yn dirprwyo ar ran Vaughan Gething) Labour (substitute for Vaughan Gething)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Mick Antoniw	Aelod Cynulliad, Llafur, yr Aelod sy'n gyfrifol am y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru) Assembly Member, Labour, Member in charge of the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill
Joanne Barnes-Mannings	Swyddog Allgymorth Cymunedol, Ymwybyddiaeth Asbestos a Chefnogaeth Cymru Community Outreach Officer, Asbestos Awareness and Support Cymru
Hannah Blythyn	Cydgysylltydd Ymgyrchoedd a Pholisi Uno'r Undeb Campaigns & Policy Co-ordinator for Unite Wales
Mary Burrows	Prif Weithredwr Arweiniol GIG Cymru, Fforwm Clinigol Cenedlaethol Lead Chief Executive for NHS Wales, National Clinical Forum
Paul Davies	Aelod Cyswllt o Athrofa Iechyd a Gofal Cymdeithasol Cymru Associate of Welsh Institute for Health and Social Care
Yr Athro/Professor Peter Donelly	Dirprwy Ddeon Uwchraddedigion, Deoniaeth Cymru Deputy Postgraduate Dean, Wales Deanery
Dr Helen Fardy	Arweinydd Ad-drefnu Gwasanaethau Pediatrig, Deoniaeth Cymru Reconfiguration Lead for Paediatrics, Wales Deanery

Yr Athro/Professor Derek Gallen	Deon Uwchraddedigion, Deonoiaeth Cymru Postgraduate Dean, Wales Deanery
Dr Jeremy Gasson	Arweinydd Ad-drefnu Gwasanaethau Obstetreg a Gynaecoleg, Deoniaeth Cymru Reconfiguration Lead of Obstetrics and Gynaecology, Wales Deanery
Vaughan Gething	Aelod Cynulliad, Llafur Assembly Member, Labour
Yr Athro/Professor Michael Harmer	Cadeirydd, Fforwm Clinigol Cenedlaethol Chair, National Clinical Forum
Marie Hughes	Cymorth Mesothelioma, Grŵp Cymorth Dioddefwyr Manceinion Fwyaf Mesothelioma Support, Greater Manchester Asbestos Victims Support Group
Joanest Jackson	Uwch-gynghorydd Cyfreithiol, Cynulliad Cenedlaethol Cymru Senior Legal Adviser, National Assembly for Wales
Lorna Johns	Swyddog Ymchwil a Datblygu Strategol, Ymwybyddiaeth Asbestos a Chefnogaeth Cymru Strategic Research and Development Officer, Asbestos Awareness and Support Cymru
Mike Payne	Swyddog Rhanbarthol, GMB Regional Political Officer, GMB
Rob Pickford	Cyfarwyddwr Gwasanaethau Cymdeithasol a Phlant, Llywodraeth Cymru Director of Social Services and Children, Welsh Government
Julie Rodgers	Dirprwy Gyfarwyddwraig Is-adran Deddfwriaeth a Polisi Gwasanaethau Cymdeithasol, Llywodraeth Cymru Deputy Director Social Services Legislation & Policy Division, Welsh Government
Tony Whitston	Cadeirydd, Fforwm Grwpiau Cymorth Dioddefwyr Asbestos y DU Chair, Asbestos Victims Support Groups Forum UK

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

Fay Buckle	Clerc Clerk
Llinos Dafydd	Clerc Clerk
Stephen George	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Olga Lewis	Dirprwy Glerc Deputy Clerk
Gwyn Griffiths	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Victoria Paris	Y Gwasanaeth Ymchwil Research Service
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service
Robin Wilkinson	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 9.02 a.m.
The meeting began at 9.02 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Mark Drakeford:** Bore da. Croeso a blwyddyn newydd dda i chi i gyd. Croeso i gyfarfod cyntaf y Pwyllgor Iechyd a Gofal Cymdeithasol yn y flwyddyn newydd.

Mark Drakeford: Good morning. Welcome and a happy new year to you all. Welcome to the first meeting of the Health and Social Care Committee of the new year.

[2] Nid wyf yn mynd i wneud y datganiadau ffurfiol arferol. Fel yr ydych i gyd yn gwybod, rydym yn gweithredu'n hollol ddwyieithog ac y mae'r cyfieithiad ar y pryd ar gael ar sianel 1, os oes unrhyw un am ddefnyddio'r offer.

I am not going make the usual formal announcements. As everyone knows, we operate entirely bilingually and the simultaneous interpretation is available on channel 1, if anyone wants to use the headsets.

Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Sesiwn Dystiolaeth 1
Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Evidence Session 1

[3] **Mark Drakeford:** Awn yn syth at eitem 2 ar yr agenda, sef y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru). Dyma'r sesiwn dystiolaeth gyntaf ac yr ydym yng Nghyfnod 1 o'r broses. Diben rhan gyntaf cyfarfod heddiw yw cymryd tystiolaeth lafar ar y Bil a chlywed gan yr Aelod sy'n gyfrifol amdano, sef Mick Antoniw—yr ydym i gyd yn ei adnabod.

Mark Drakeford: We will move straight to item 2 on the agenda, namely the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill. This is the first evidence session and we are at Stage 1 of the process. The purpose of today's meeting is to take oral evidence on the Bill and to hear from the Member who is in charge of it, namely Mick Antoniw—we all know him.

[4] Yn ymuno â Mick y mae Vaughan Gething. Rydych i gyd yn gyfarwydd â Vaughan fel aelod o'r pwyllgor. Mae Vaughan yn cefnogi Mick yn y broses. Gyda ni hefyd y bore yma, wrth y bwrdd, y mae Paul Davies, aelod cyswllt o Athrofa Iechyd a Gofal Cymdeithasol Cymru, a hefyd Joanest Jackson. Mae pawb yn gyfarwydd â Joanest.

Vaughan Gething is with Mick today. You are all familiar with Vaughan as a member of this committee. Vaughan is supporting Mick in the process. Also with us this morning, at the table, is Paul Davies, who is an associate of the Welsh Institute for Health and Social Care, and Joanest Jackson. Everyone is familiar with Joanest.

[5] Mae Lynne Neagle wedi ymddiheuro ar gyfer sesiwn y bore, ond bydd yn ymuno â ni'r prynhawn yma. Felly, croeso mawr i Julie Morgan a Mike Hedges sydd wedi ymuno â ni heddiw ar ochr y Blaid Lafur gan fod Mick a Vaughan yn rhoi tystiolaeth. Mae Mike yma tan 10 a.m. ac y mae Julie gyda ni tan 11.30 a.m.. Diolch i chi'ch dau am ein helpu ni y bore yma.

Lynne Neagle has sent her apologies for this morning's session, but she will be with us this afternoon. Therefore, I warmly welcome Julie Morgan and Mike Hedges, who are with us today on the Labour side because Mick and Vaughan are giving evidence. Mike will be with us until 10 a.m. and Julie will be with us until 11.30 a.m.. Thank you both for helping us this morning.

[6] Rydym yn mynd i wneud pethau fel yr ydym yn eu gwneud fel arfer. Rwy'n mynd i ofyn i Mick ddechrau gydag unrhyw sylwadau agoriadol byr ac, ar ôl hynny, rwy'n mynd i droi at aelodau'r pwyllgor iddynt ofyn eu cwestiynau.

We are going to do things as we usually do them. I am going to ask Mick to start with any brief opening remarks and, after that, I will turn to committee members for them to ask their questions.

[7] Mick, if you want to lead off with an opening statement, we will then just move straight into questions.

[8] **Mick Antoniw:** There are a few opening comments from me and Vaughan that we wanted to make. The first opening comments that I would like to make are about why this Bill is being brought forward, what it is about and the purpose of this legislation. It is essentially about some way to improve or make better the conditions of the people of Wales. What we do know is that asbestos has a long and dark legacy within Wales; it is a significant cause of death and illness as a result of a very specific form of work or exposure. The primary purpose of this Bill is to mirror what happens already by way of precedent within the road traffic accident scheme whereby, I suppose, the polluter pays. That is, where it is established that someone has, as a result of their negligence or failure to comply with the law, injured someone else as a result of asbestos exposure, we should be able to recover the cost that the NHS pays for the medical treatment of that from those persons, with the intention that that money will be used to add value and benefit to the people and their families who have suffered from that disease. That is the intention. With that objective, it seems to me that if we are able to recover those sums, it could make a significant and valuable improvement to the quality of life of asbestos sufferers and their families.

[9] **Vaughan Gething:** Briefly, filling in some of the practical points about how we seek to achieve that, Mick has already mentioned the Road Traffic (NHS Charges) Act 1999, and the Bill follows a very similar path in the way in which it is set out and in how it seeks to achieve that in recovering those NHS costs. The compensation recovery unit issues certificates, there is a process for review and appeal, and the system uses a tariff. We made a very practical choice about looking for a system where there was not going to be a costly individual assessment of individual medical records. A tariff scheme was already well established under the 1999 Act, which was expanded substantially by the Health and Social Care (Community Health and Standards) Act 2003, whereby in the case of all personal injuries where a compensation payment is made, apart from diseases, NHS costs are already recovered. We believe that there is a very good case for recovering asbestos-related disease costs. That is why this Bill is before us. I should also point out that there is obviously more detail in the explanatory memorandum. We estimate about £2 million a year for the first four years as the benefit that can be recovered. In particular, I will just draw your attention to section 16 of the Bill, which is where we try to ensure that when Welsh Ministers recover that money for the NHS, they are then under some form of duty to give regard to ensuring that the money recovered goes into benefitting the treatment of asbestos-related disease or supporting people affected by asbestos-related conditions.

[10] **Mark Drakeford:** Thank you both very much. Are there any questions from Members?

[11] **William Graham:** You will have seen what the Association of British Insurers said. I will quote from it:

[12] 'the practical and material disadvantages of extending the recovery scheme to disease claims outweighed the potential benefits'.

[13] How would you answer that?

[14] **Mick Antoniw:** Quite frankly, I think that it is wrong. I think that we can do something that is simple and cheap and which adds to a system that already exists in respect of road traffic accidents. It makes a material improvement to the capacity of the NHS in Wales to give added value and health support to those particular victims. It is not unreasonable to say that where someone has been to blame for something, if they could do something to restore or improve the quality of the remainder of the victim's life, then that is worth doing. Quite simply, it probably comes down to asking whether this is something that it is right to do, and in my view, it is.

[15] **Rebecca Evans:** I am glad that Mick Antoniw has brought forward this Bill; it has had a warm reception from the people affected by asbestos-related diseases. I wonder whether you think that the principle of recovering the costs to the NHS should be extended to all diseases where a compensation payment has been made.

[16] **Mick Antoniw:** This Bill has been carefully drawn up to be confined solely to the matter that we were concerned with. I have been working on this with Vaughan and others as a team, and it is about the particular problem of asbestos disease. In my previous work, I had a lot of experience of dealing with people on this issue. So, it is focused on that and it is probably not appropriate therefore to say, 'Well, what if you go into other areas?' and so on.

[17] All diseases are very complex and have very different factors, but what we know about asbestos disease is that it is relatively easy to identify and to confine its cause. For example, we know that mesothelioma is only caused by asbestos exposure. There are no other causes. We also know that in countries such as Wales—the same is true of other parts of the UK—there is a particular legacy and, to some extent, it is about doing something to resolve the consequences of that particular legacy. As I said in earlier debates on the asbestos issue, that is why we have confined it to asbestos and why this is about asbestos and nothing else.

[18] **Rebecca Evans:** You refer to the particular legacy that we have here in Wales. The evidence from Asbestos Awareness and Support Cymru states that the Bill would demonstrate to the rest of the UK and to the world that Wales recognises the damaging effects that asbestos has had upon workers. Are you aware of any similar situations internationally or any schemes that exist that are similar to the one that you are proposing?

[19] **Mick Antoniw:** I am not. Various arrangements have been put in place around the world where there has been an asbestos industry. I am thinking of America in particular, where asbestos companies have folded and their residual resources have gone into providing support. Of course, America has a very different healthcare system. Vaughan and I were very much involved with the asbestos issue in South Africa, where asbestos workers and miners lived in areas where not only was asbestos mined, but the roads and houses were constructed with asbestos components and there was a life expectancy of 37 years. When those companies were winding up, because of the loss of a big chunk of their market, we were involved in working to ensure that those funds were put into a trust to provide benefits to the families for the residual legacy. This is very much within that same vein. This particular legislation, in respect of asbestos, is probably a first for Wales. This will be the first time that any legislature has adopted this particular approach, certainly within the UK. Of course, within the world, you have to look at the different systems that are in place. We know that asbestos is probably the biggest killer, of any cause—including small wars, probably—in the entire world.

[20] **Kirsty Williams:** Have you made any assessment of the possible adverse impact on those claiming damages if the claim for the recovery of the NHS charges is seen as another reason for somebody to contest liability? Have you made any assessment of that process? The Bill goes on to say that ongoing NHS charges after the claim has been settled are not liable for recovery. If this is about making the polluter pay, why would we stop that process before

the process had been completed? The NHS goes on to incur charges, yet your Bill limits that, so I am interested to understand why that is the case. If we are pursuing people for the cost that they have put upon the NHS, why would we suddenly decide that ongoing costs are not appropriate?

[21] **Vaughan Gething:** I will deal with the keep-on-fighting point and then Mick will deal with the point about the cut-off. We certainly considered this point, and it was raised with us by a number of other people, as to whether this additional cost will mean that insurers will decide to keep on fighting because there is an additional cost to the final one that they can be liable for. We think that, if anything, this provides a greater incentive to settle early because you know that you are going to have to pay an additional cost. In matters of asbestos-related disease, liability is often relatively straightforward. If you can demonstrate that you worked in a workplace where you were exposed to asbestos, and you have an asbestos-related condition, it is not always that difficult for a court to find that there is liability on the insurer of the employer that has exposed someone to an asbestos condition.

9.15 a.m.

[22] We do not think that this will result in people fighting for longer. After all, lawyers who represent employers and their insurers are under their own individual obligation to try to assess the value of the claim and its liability. The longer you prolong that, the more costs you add and the greater the liability you build up for your own clients. We understand the argument being made, but we do not think it stands up in practice; that comes from the reality of our practice. It is also worth pointing out that those same points were raised in advanced of the 1989 scheme that came in under the Road Traffic Act 1988, under a Conservative Government, and in the 2003 Act that extended that scheme to all personal injuries, apart from disease, where compensation was paid. We have not seen, in reality, any significant additional effort by employers or insurers to keep on fighting those claims. It would be pretty odd if this were the only instance where that happened.

[23] **Mick Antoniw:** I will first deal with the post-liability costs and why there is a cut-off date. We are mirroring the precedent that already exists with the road traffic scheme and other legislation—recovery of benefits legislation—in personal injury cases. The main reason is that if you do not have a cut-off date, you have no certainty as to how much you are going to recover and when you are going to recover it. You must also then have an administrative system that is continually examining the ongoing costs. We think that it can probably be more easily dealt with by virtue of the fact that, in those cases, you often have what are called provisional damages, where compensation is settled on liability of an asbestos disease on the grounds that it will not deteriorate. In this particular case, that would trigger liability for the costs up to that particular date.

[24] The provisional damages part means that the parties can come back to court at a later stage if they develop a further asbestos-related disease—if they go on to develop lung cancer or mesothelioma, which is a cancer of the lining of the lungs. As much as anything, it is about keeping the administrative cost down. It is also about giving clarity to the NHS, or the Welsh Government, as to the amount it is likely to recover. In fairness, we also want to give clarity to the insurance industry, so that when it is assessing what its liabilities are and what it is going to cost them, which is quite important in the work that it does, it knows what it is going to be liable for up to a particular stage. With the cut-off date, I echo Vaughan's point that it creates an incentive to conclude matters as early as possible. The sooner an insurance company says, 'Yes, we hold our hands up and accept that we are to blame and will now pay the compensation. On top of that, because of this legislation, we have to pay medical costs', the more we minimise the costs for which they are liable. It is about clarity and minimising the cost of administration.

[25] **Lindsay Whittle:** This is a cause that everybody wants to support, but I have worries about the complexities of the claims, because they can run for a long time in courts. Who will bring the claim to the courts? I hope that it is not the victims and their families. The compensation is for the medical costs. However, it does not seem that those medical costs, where a claim is successful, will go back to the NHS. I thought that that was the whole purpose of this, so can you explain it to me?

[26] **Mick Antoniw:** This legislation does not interfere with the compensation or legislative processes. The establishment of liability in a case triggers an entitlement to the Welsh Government at that stage to recover its costs. It is not dissimilar to what happens with the UK Government and benefits that are paid to an individual during a compensation claim where, at the end, the Government has an entitlement to recover the cost of the benefits that have been paid. To some extent, that sets out a little of the precedent in this example.

[27] We have made clear that we are not concerned with the process of compensation. We are concerned that the system operates effectively and simply. We are only concerned with the position once all of the legal aspects have been resolved by the other parties. We do not give much attention to how or when a claim is brought, or to who brings it, because this legislation only kicks in once an employer or insurance company accepts that it is to blame. That then triggers the liability.

[28] In terms of where the money goes, that would ultimately be up to the Welsh Government to determine. Section 16 of the Bill, which I think Vaughan has mentioned, is specifically about saying that there is a purpose to this Bill. This Bill is not just about recovering money for the sake of it, with the money going into the black hole of NHS coffers. We want to show at the end of this process that whatever money has been raised in this way, it has gone to improving health and treatment, perhaps through research, equipment or whatever. We want to show that it has provided additional health value to those people who suffer from these diseases and to other people who are affected, such as the families. That is why that section is in there. It is to make sure that that happens, and also to highlight the fact that this legislation is about showing, demonstrably, at the end of the process, that this legislation will improve the quality of life of a particular category of people in Wales.

[29] **Vaughan Gething:** I would like to pick up the point about compensation. This is not a compensation Bill. This is about the recovery of NHS costs that have already been expended, rather than any additional compensation. The latter is exactly what we are not concerned with. For a start, we know that that issue is not within the powers of the Assembly, but recovering NHS costs is.

[30] **Kirsty Williams:** However, there is a link there. I appreciate that the legislation does not seek to cover that but, as we established earlier, we have received evidence that this legislation could impact on the process by which compensation, and a claim for compensation and liability, is conducted. I appreciate that you have said that you do not believe that the outcomes are as they are stated to be. However, there is a linkage.

[31] **Vaughan Gething:** The point is that this does not affect any entitlement to compensation. That is a wholly different process, and one that we are not affecting here. This simply triggers the entitlement to recover NHS costs, exactly as the Road Traffic (NHS Charges) Act 1999 does. It is exactly as Part 3 of the health and social care Act 2003 does as well. It is something that is consequential, but it does not affect the compensation system at all. It is not about changing that; it is about recovering NHS costs.

[32] **Lindsay Whittle:** With respect, Chair, the compensation to the victim—with which I fully agree—is already settled. That is the compensation claim, and it should be an amount of money—if the victim is still with us—to help them live a life that is as full of value as

possible. Compensation for NHS costs is just that, I thought.

[33] **Vaughan Gething:** This is about the recovery of NHS costs, based on a tariff system.

[34] **Lindsay Whittle:** With respect, Mick mentioned that the recovery of NHS costs can also go toward helping the victim. So, are you going to help the victim twice? I might not disagree with that. However, the whole essence of the Bill is the recovery of medical costs. If I crash my car and I recover the costs of the garage repairing it, the money should go to the garage repairing the car, not to me again.

[35] **Mick Antoniw:** I would like to provide an example. There was a phrase spoken in the earlier debates—I think it was by Darren Millar—that contained a very valid point. In the case of someone who is unfortunately suffering from an asbestos-related disease and brings a compensation claim, if they choose to have private medical treatment, as part of their compensation claim, they would be able to recover the full cost of that medical treatment. That could be hospice care, extra medication or a whole series of things. They are entitled to do so. To some extent, this legislation puts the NHS on the same path as the private sector, bringing a certain amount of parity and equality. This is in the sense that, at the moment, the NHS does not have that entitlement. The individual can claim it if he pays it, but the NHS costs have never been a factor. So, in this case, we have decided to adopt a dual approach. One element is to say, 'Well, let us put the NHS on the same footing, so that those costs can be recovered.' However, we do not want to recover those costs just for the sake of recovery. We want to have a discernible product at the end. The discernible product is that people with asbestos disease and their families will have additional added-value support and treatment, which I think is something that is not additional to what they are already getting from the NHS.

[36] **Lindsay Whittle:** Finally—and forgive me as I do not know how many people have suffered or are still suffering from this terrible disease—have we any indication of how much money could possibly be recovered?

[37] **Mick Antoniw:** The figures relating to mesothelioma are the easiest to identify, because once this disease is diagnosed, it is terminal and death occurs very quickly. This is also where we have done the most work in terms of the valuation of the cost of it. We know that there are approximately 90 deaths a year from mesothelioma and that that will continue for the next decade or so. With asbestos-related lung cancer, which can result in death or contribute to death, the Health and Safety Executive estimates that there are probably a similar number of deaths as a result of that. With the other asbestos diseases, it is more a case of how they impact on the quality of life, such as asbestosis, pleural thickening and so on in terms of respiratory disease.

[38] So, it is significant. I think that the totality of cases per annum for the four categories of disease—and it is difficult to be precise about the figures—is approximately 400 to 450. With mesothelioma, we would expect that if 80 out of those 90 resulted in a liability judgment, which then triggered the entitlement to cost, we would recover around £2 million per year. So, we are probably talking of a figure of between £2 million and £3 million a year in recovery, which is the sum that we would like to see going towards providing that additional support to asbestos victims and families.

[39] **Lindsay Whittle:** I hope that it is not in the solicitors' charter, but you do not envisage solicitors querying the cost—heaven forbid—of the medical costs and it being dragged through the courts.

[40] **Mick Antoniw:** No. The beauty of the system is that it keeps out the lawyers because it only triggers liability. The involvement of the lawyers is early on. The sole interest of the

Welsh Government is that liability and all of that stuff is dealt with. Our concern now is a simple system for the recovery of our costs and then how we use that money.

[41] **Mark Drakeford:** Rebecca has a point on this.

[42] **Rebecca Evans:** How will costs recovered in incidences where compensation claims are decided outside of England and Wales, but where treatment takes place in NHS Wales, be recovered?

[43] **Vaughan Gething:** We considered this in terms of the scope of the Bill. It is about treatment that NHS Wales pays for. So, that treatment would normally take place within Wales, but it is possible that some of that will take place outside of Wales. That could be for people who live in Wales but in a border area and so would go over the border to have treatment. If someone has treatment elsewhere but NHS Wales is responsible for the cost, that is a cost that NHS Wales will be entitled to recover. Otherwise, we are concerned that we are actually going outside the scope within which we are entitled to make laws.

[44] To pick up on the point about the amount, we estimate in the explanatory memorandum that around £2 million a year can be recovered for the first four years. Work done on this shows that there are around 450 cases a year where asbestos-related conditions are treated within NHS Wales. If people are interested in having more information about the tariff, Paul Davies can deal with that.

[45] **Mark Drakeford:** Just to be clear on Rebecca's point, are you saying that it does not matter where the compensation claim is determined?

[46] **Vaughan Gething:** That is correct.

[47] **Mark Drakeford:** It could be determined anywhere. If the costs fall on NHS Wales, they will still be capable of being recovered, even if the compensation element was determined in Scotland, for example.

[48] **Vaughan Gething:** That is correct.

[49] **Mick Antoniw:** It does not matter either where the exposure occurred as long as it is within the UK. It is purely a matter of what NHS Wales has paid out; it triggers the entitlement to cover that.

[50] **Mark Drakeford:** Thank you. We will now go to Mike, and then to Julie and Elin.

[51] **Mike Hedges:** You have mentioned the road traffic Act a great deal. How does this differ from the road traffic Act? When the road traffic Act came in, were there any problems with people getting compensation because of the additional costs? I take it from this that liability has already been decided, that is, who is responsible, so you do not have a situation where the docks are arguing with the steelworks, which are arguing with the energy generator about from which one the boilermaker picked up asbestos. I take it that has already been done.

9.30 a.m.

[52] **Vaughan Gething:** The issue of responsibility for making a payment has already been dealt with, otherwise the Bill's recovery provisions are triggered. Going back to the Road Traffic (NHS Charges) Act 1999 and the Health and Social Care (Community Health and Standards) Act 2003, there has not been any significant problem in recovering those costs, and, again, going back to the point that Kirsty made earlier, there has been no

significant change in the way that insurers deal with these claims. They still deal with the claims on the same basis and there is no extra fight on liability, because NHS charges are being recovered. We do not anticipate, given that significant precedent, that there will be any significant difference here either.

[53] **Mike Hedges:** I want to ask you about the meaning of the word 'significant', although it is always a difficult question to ask somebody who is involved in law.

[54] **Vaughan Gething:** In the claims that I used to run, I never noticed any difference at all. That is the honest truth. When you look at figures in terms of the time that it takes for claims to be run and won and the way in which liability decisions are made, you see that this does not affect them.

[55] **Mr Davies:** To build on that a little, the number of claims that are made in Wales on an annual basis, both for road traffic accidents, which is the majority, and for personal injury is over 20,000 every year. That process is efficient, timely and very cost-effective. My experience from the NHS is that it can be done quite quickly, so when you add on this small number of cases, which what we are talking about, it is not a major issue from an administration point of view at all.

[56] **Julie Morgan:** I was going to ask about the road traffic Act and how it operates, but I think that Mike has covered most of that. In terms of the amount of money that has come in from the road traffic Act, is it what was anticipated? Was there an estimate of how much that would bring in, and did that amount come in?

[57] **Mr Davies:** In the NHS, we are legally obliged to put in a provision of 10% to cover the potential for failure to pay, but we are well within that in terms of recovery, and, because the compensation trigger has already been made, there are no legal issues to do with saying whether there is a liability. The liability is already there; it is just the trigger and because, under the preferred option, it is dealt with by the compensation recovery unit, that process works very effectively and is timely. You do not have cases that go on for months and months. These are done very quickly, within a matter of weeks.

[58] **Julie Morgan:** During the process of preparing this Bill and coming forward with it, has anything come up that has made you change course a bit or made you think that there are particular problems? I am very much in support of the Bill, but we want to get the details right, obviously.

[59] **Mick Antoniw:** When we started thinking about the format of the Bill, the fact that there was an already well-established precedent in legislation made that a suitable model to take forward. However, in order to tie asbestos into that, we had to look at the efficiency of this system, and we decided, as we went along—Paul Davies can perhaps add a little to this later, because he did some work on it—that we would be spending too much on administration if we were to look at primary care costs and a lot of incidental NHS costs around this. However, if we mirrored as closely as we possibly could the road traffic scheme, which is predominantly an in-patient tariff system, that would enable us to recover the biggest chunk of the costs that were incurred for the least expenditure. That is why we have adapted it and snipped bits off. Initially, you think, 'We should be including every single item that we possibly can', but then you start analysing it. It was one of the points that was made in the Association of British Insurers' talk about when the road traffic scheme was introduced; it specifically precluded asbestos diseases because it was just not proportionate or viable to include them. However, that was very much in the context—I remember it well, because I was involved in giving evidence during the process—of looking at a whole raft of different diseases, including musculoskeletal diseases and so on. The difference between that and what we are doing here is that, in some ways, asbestos disease is something that you can confine

and identify clearly and simply. The explanatory memorandum and the information in that, and the way in which the Bill has been drafted, probably proves the point on that.

[60] **Julie Morgan:** So, you decided to exclude primary care, physiotherapy and those sorts of things on the grounds of administrative simplicity, basically.

[61] **Mr Davies:** The brief that Mick gave me initially was that, ideally, we wanted to include all costs, and I think that that is the right approach, but then we had to match and balance that with the practicalities of carrying out the costing exercise. I went through 11 cases in detail, and there is a lot of detail. Looking at the different events and interventions that patients undergo over a fairly short period of time—a year to 18 months maximum—and working out the costs on an individual patient basis, what gave me confidence, and I was quite surprised by this, was that, when I applied the tariff to those actual costs, 80% of them were driven by in-patient stays. We went into every cost bar primary care, although in the mesothelioma cases I would say a large proportion of the care is hospital-based, and there is little on the primary care side. Therefore the tariff, which is basically the method that is applied for the road traffic and personal injury cases, recovered the costs more or less, certainly within 1% of the actual cost. I was confident that in balancing this organisational fit—that is, having something that was administratively simple—with recovering the costs that Mick was looking for, this comes up with a good answer.

[62] **Mick Antoniw:** It was also very much a point that was raised by Elin and Kirsty in the introductory debate on this—what is this all going to cost? Do we want a system where you recover money, but you spend most of it on administration? We were very aware that we had to come up with a system that would be for minimal cost, would be efficient and would not create burdens on the NHS itself. The way in which we proceeded was to look in particular at the compensation recovery unit as a mechanism. That is one of the main options, and probably the most viable one. It is an ideal way forward, because every single case that we are concerned with will already have been registered with the compensation recovery unit.

[63] **Vaughan Gething:** It is a process that insurers themselves are used to and have confidence in. The process that the Bill sets out for review and appeal is again is a process that they are used to in any event. Therefore, this is not a wholly novel procedure that is being introduced.

[64] **Elin Jones:** I have three questions. First, have you made any assessment of whether there will be an increased cost of insurance for businesses working in this field in Wales, or other businesses based in Wales, upon the introduction of legislation of this sort? On the cost to the Welsh Government, you said earlier, Mick, that part of the beauty of this Bill as it stands is that there is not much scope for lawyers to get involved, but there is, of course, an appeals process in there, and there is a reference to appeals to a tribunal, so the Welsh Government could find itself in the position of having to contest on that basis. I failed to find this in the explanatory memorandum as I was thinking of this just now, but is it in there? Have you made an assessment of the cost to the Welsh Government of the appeals process and its involvement in it?

[65] Thirdly, on where the money goes once it is recovered, I quite like the model where the money goes back to the health board that has faced the cost. There could be numerous cases in particular areas of Wales, and it would be more relevant to reimburse the health board involved, but you have chosen a different path.

[66] Section 16, which you have referred to, is pretty woolly in wanting the Welsh Minister to have regard to the desirability of the money being spent in a way that is related to the disease. However, you have not chosen, for example, to say in section 16 that you would want the Welsh Minister to report on this annually to the National Assembly or to be

accountable in a very specific way on this. I wondered why you have chosen to be pretty unspecific in how you would want Welsh Ministers to be accountable for your desire for this.

[67] **Mick Antoniw:** We both have views on this issue of the increased cost of insurance. What we are talking about are liabilities now that were paid for previously, and the insurance industry has, by and large, had the premiums and the benefit of investing that money and making a profit from it and so on. It is therefore very much a case of liabilities that have already been paid for, because, with asbestos, as you know, the latency period can be anything from 10 to 50 or even 60 years—perhaps 10 to 40 years is the latency period. So, at the moment, the majority of the cases that we are dealing with are ones in which exposure occurred up to two decades ago.

[68] As for any potential future impact, we do not think that there should be one, because companies that take out employers' public liability insurance now should be assessed on their risks as they currently exist. For any current company employer, corporate body or whatever to limit its liability, essentially it just has to show and ensure that what it has in place now are proper systems for monitoring, assessment and so on. Asbestos is not used as a product as it was in the past, so we are more concerned with the monitoring and control of future potential exposure, as we know from the schools issue that has arisen. So, they can limit the liabilities that way. To that extent, we have always known the risk between this liability in the insurance area and the extent to which organisations and employers ensure that they comply with the safety legislation. To that extent, future companies really just need to make sure that they have proper systems in place, and they should be able to limit their liability.

[69] Of course, we cannot dictate how the insurance industry operates, but I would suggest that it would be very unreasonable for an insurance company to want to impose past liabilities on future customers.

[70] **Vaughan Gething:** On this point about premiums, if you look at what has happened with the expansion of NHS recovery of costs in the two pieces of legislation that we have referred to, when we met representatives of the ABI—and we have met them—they were not able to point to an increase in premiums that had resulted from that significant extension of NHS costs being recovered. We are talking about a relatively small number of cases. We are talking about £2 million being recovered. Of course, you would expect the insurance industry to say that this will lead to higher premiums—that is not exactly a surprise—but we are not aware that there is any evidence to support that. Equally, there is this point about whether this is a Bill that is worth having. Is it worth producing this Bill to recover money for the NHS in Wales in terms of money that has already been paid out to treat people with asbestos-related conditions? That is a choice that we as legislators will have to make. It is a choice that Parliament has already made with regard to road traffic accidents, and now, all forms of personal injury, apart from disease, where compensation has been paid.

[71] **Mick Antoniw:** On the other point that you raised, on the appeals process and whether this is likely to create any additional burdens, with all systems, you must have an appeals process. In terms of the road traffic thing, I was involved in that area, going back almost two decades, and I do not recall there ever being a legal appeal insofar as someone challenged by way of judicial review or whatever. Most of these things are, essentially, administrative matters. That is, you would be querying whether you have the right person, whether it is the right number of stays and how the tariff is calculated, or that these stays were not due to certain factors, et cetera.

9.45 a.m.

[72] In the handful of cases in which I remember being involved in the past, they were almost correspondence, or administrative measures, where you were getting checks on how

the calculations were performed. I would not anticipate any significant cost, and although there is always a potential cost, it is a very remote possibility that will very much be contained within the costings.

[73] **Elin Jones:** Is there anything in the cost-benefit analysis that you have done that relates to costs to the Welsh Government—

[74] **Mick Antoniw:** No, because there was very little evidence of this having a significant impact on, or creating a problem in relation to, the road traffic accident scheme, for example. In fact, with regard to the road traffic accident side of things, the average cost is, I think, well under 3%.

[75] **Elin Jones:** I also asked a question on section 16.

[76] **Mick Antoniw:** Section 16 is, to some extent, pretty woolly. It is more of a question of thinking about what should be in the legislation and to what extent you can bind Government to a system that becomes too inflexible. One of the reasons is that some people presenting with an asbestos-related disease may have other conditions; there may be a certain degree of comorbidity. We know that the risk of developing lung cancer is increased massively by smoking, so the two very often go hand in hand. So, there is an apportionment system within the scheme to allow for that in the event of a judgment on that.

[77] In terms of how we hold the Government to account for the way in which the money is used, I expect that there would be an annual report from the Minister about how the money has been used; I would have thought that a Minister would want to do that. I would certainly hope that this committee will put specific questions to get guarantees on the record from the Minister that the money raised will not be diverted or substituted for other things, and that the legislation will be complied with, and that the Government will be held to account by reporting on the way in which the money is used each year. I think that the Assembly, if it passes this legislation, will want the Minister to come back each year to explain to it what the benefit and the product have been to all this effort.

[78] **Elin Jones:** Do you have an objection to an amendment to this Bill extending section 16 and requiring an annual report by a Welsh Minister to the National Assembly?

[79] **Mick Antoniw:** I have no objection to the principle and the idea, and it is something that we had included in our early drafts. It was just a question of whether it was appropriate to put it within the legislation—what it would mean and what it would do—as opposed to seeking an assurance from the Government, so that there was a clear commitment on the record.

[80] **Vaughan Gething:** A point was made about why the money should not be directed back to LHBs. If you were going to get £2 million that would then be split up between different boards, we questioned whether you would get real value for that money and whether you would get more value in having one fund whose money could be directed into projects. For example, if you wanted to put money into a research project for the treatment of an asbestos-related condition, which, I think, the Bill would provide for, you might have to have a sum of money that comes from more than one health board. For example, would it make sense for Powys Teaching Local Health Board, when none of the treatment takes place in the county, to receive much smaller sums of money than Aneurin Bevan Local Health Board, and does that make sense in terms of that money being able to demonstrate a definable benefit? We took the view that there would probably be greater utility to having one fund where that money can go back, and then allocate it in a way that we would expect, in order to be transparent in how that £2 million or so for the first four years is going to be used.

[81] **Kirsty Williams:** Except that Powys—[*Inaudible.*]—treatment in another hospital, so the liability would be on Powys.

[82] **Vaughan Gething:** There is a fairly small number in Powys compared with other health boards, so you would be talking about much smaller sums of money. Powys may get greater benefit from having, for example, additional money that goes into a project in Aneurin Bevan where a number of Powys residents could end up going for that treatment. That is why we took that view.

[83] **Mark Drakeford:** Would committee members object if we extended this session just for five minutes, because there are three quick points that I want to get on the record as part of our Stage 1 proceedings? I see that there is no objection. The first point is that the Presiding Officer has ruled that the Bill is within competence, but has written to committee members—you will have a copy of the letter in your bundle for today—explaining how she came to that conclusion. Are there any issues on competence that you think the committee needs to be aware of? We know from other witnesses' written evidence that they intend to raise issues of competence with us. Is there anything that you want to put to us on those issues as part of today's proceedings?

[84] **Mick Antoniw:** Only that, first, we are pleased that the Presiding Officer has endorsed the fact that this is within competence. As you would probably expect, I understand, bearing in mind the legal status of some competence issues, that one or two other points have been raised. However, endorsement has been given. Secondly, in almost all of the debates, and in the explanatory memorandum, we have made our position on competence very clear. Health is devolved, and this is a Bill that is about the health of a group of people who have been exposed to asbestos and have suffered from it. We think that any other areas that may impinge on the competence issue are incidental aspects of the primary purpose of this legislation, which is to improve the quality of care for people suffering from asbestos-related disease.

[85] **Mark Drakeford:** On the four implementation options that the explanatory memorandum rehearses, your preference is for the scheme to be administered through the compensation recovery unit. Have you, as the Member in charge of the Bill, had any conversations with the unit to know that it would be prepared to undertake this work?

[86] **Mick Antoniw:** I have not been in a position to do so personally, because the CRU's relationship is with the Welsh Government. However, I know from working with the Welsh Government on this that it has had contact with the CRU. You can see from the explanatory memorandum that it already makes an annual payment to the CRU for its services in respect of road traffic cases, which I think is £155,000 a year with a return of around £15 million. The position of the CRU at present, as I understand it, is that there do not seem to be any particular reasons why the system cannot be adjusted to accommodate this. However, until the legislation is passed, and until you have the business case in which the Government states what it wants to do, it is not in a position to take this further forward. My view is that this would be a simple and natural addition to what the CRU does, and I do not see any particular complications or reasons why it should not proceed as a cost-efficient system.

[87] **Mark Drakeford:** Finally for this morning, you know that the committee will always be interested in whether the Bill gets the right cut with regard to those things that appear on the face of the Bill and those things that are left to regulation-making powers given to Ministers. The Bill does not include details of the appeals process, which it leaves to Ministers; is that right or fair? In response to Elin's question, I believe that you said that it is right and proper that there should be an appeals process. Is it not fairer to those people who want to operate an appeals process that that process should be transparently there on the face of the Bill rather than being left in the hands of Ministers to determine?

[88] **Vaughan Gething:** This matter is considered in every piece of legislation where there is a regulation-making power, particularly where there is a review and appeal process. We took the same view that pretty much every other piece of legislation has taken on a similar point, whether it is on food standards, this issue or, for example, the Road Traffic Act 1988 and the expanded Health and Social Care (Community Health and Standards) Act 2003; they have all left that review and appeal process to regulations. That is partly about the flexibility that you would need with regard to making changes to the timescale from time to time. We have, therefore, made pretty clear provision on the face of the Bill regarding the basic requirement of an appeal and review process. However, we think that it is the right split to leave the detail of that to regulations.

[89] **Mark Drakeford:** Diolch yn fawr iawn i chi am ddod i'r pwyllgor y bore yma i'n helpu gyda'r broses o ddechrau Cyfnod 1 o'r Bil hwn.

Mark Drakeford: Thank you very much for coming to the committee this morning to help us with the process of starting Stage 1 of the Bill.

9.55 a.m.

Cynnig o dan Reol Sefydlog Rhif 17.42(ix) i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order No. 17.42(ix) to Resolve to Exclude the Public from the Meeting

[90] **Mark Drakeford:** Cynigiaf

yn unol â Rheol Sefydlog Rhif 17.42(ix), fod y pwyllgor yn penderfynu cwrdd yn breifat ar gyfer eitemau 4, 7, 8 a 12.

Mark Drakeford: I move that

in accordance with Standing Order No. 17.42(ix), the committee resolves to meet in private for items 4, 7, 8 and 12.

[91] A yw'r Aelodau i gyd yn fodlon â hynny? Gwelaf eich bod.

Are all Members content with that? I see that you are.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 9.55 a.m.
The public part of the meeting ended at 9.55 a.m.

Ailymgynullodd y pwyllgor yn gyhoeddus am 10.05 a.m.
The committee reconvened in public at 10.05 a.m.

Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Sesiwn Dystiolaeth 2
Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Evidence Session 2

[92] **Mark Drakeford:** Bore da a chroeso i bawb, a chroeso cynnes i'r rhai ohonoch nad ydych wedi bod i'r Cynulliad Cenedlaethol o'r blaen.

Mark Drakeford: Good morning and welcome to everyone, and a warm welcome to those who have not been to the National Assembly before.

[93] We will do some parts of the session in Welsh, and anyone who needs interpretation can use the headsets. You will find the interpretation service on channel 1.

[94] Rydym yn bwrw ymlaen yn awr gydag eitem 5 ar ein hagenda. Byddwn yn cymryd tystiolaeth ar y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru) gan grwpiau sy'n cynrychioli'r rhai y mae clefydau asbestos wedi effeithio arnynt. Hoffwn groesawu Joanne Barnes-Mannings a Lorna Johns, sy'n cynrychioli Ymwybyddiaeth Asbestos a Chefnogaeth Cymru. Hefyd gyda ni y bore yma y mae Tony Whitston a Marie Hughes, sy'n cynrychioli Fforwm Grwpiau Cymorth Dioddefwyr Asbestos y DU. Gofynnaf iddynt ddechrau gan wneud un neu ddau o sylwadau, er gwybodaeth, am y grwpiau y maent yn eu cynrychioli ac am y gwaith y maent yn ei wneud.

We will now move on to item 5 on our agenda. We will take evidence on the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill from groups that represent those who have been affected by asbestos-related diseases. I would like to welcome Joanne Barnes-Mannings and Lorna Johns, who are representing Asbestos Awareness and Support Cymru. Also with us this morning are Tony Whitston and Marie Hughes, who are representing the Asbestos Victims Support Groups Forum UK. I ask the witnesses to start by making one or two comments, for the record, about the groups that they represent and about the work that they do.

[95] We will then go straight into questions from Members, based on the evidence that we have already heard from the witnesses. If we work our way down the table, perhaps Joanna would like to begin.

[96] **Ms Barnes-Mannings:** My name is Joanne Barnes-Mannings. I am here to represent Asbestos Awareness and Support Cymru. My role in that organisation is on a community outreach basis. My own personal experience became my driving force. My dad was diagnosed with mesothelioma at the age of 62 and sadly died four years ago. As we went through that experience, my family and I at times felt isolated, lost and abandoned. There seemed to be so little knowledge and information available about mesothelioma. So, from a personal point of view, that has been my driving force. The feelings that we have experienced seem to have been echoed by the families with whom I come into contact. I tend to be their first point of contact to help them through the process.

[97] **Ms Johns:** Asbestos Awareness and Support Cymru was formed at the beginning of 2012 to offer more specific support to those affected by exposure to asbestos fibres in Wales and as a response to personal experiences. We take a collaborative approach to bringing together victims and carers, informal and professional, to improve patient care. We have a supportive focus to improve the quality of life for patients and their families. We help patients navigate the treatment process, ensure that patients receive timely follow-ups, provide a link for continued emotional support, and facilitate communication, thereby enabling services to be put into place swiftly. AASC is the voice of asbestos victims in Wales, and there is strength in the bonding and support that patients and families can get from each other. Information is available and provided on managing the practical difficulties of living with a life-limiting illness. We like to think that AASC is making life less stressful at a very stressful time. The impact of a mesothelioma diagnosis is physical and emotional; AASC focuses on the asbestos victim and his or her particular circumstances. No two patients are alike. We have an individualised approach tailored to specific needs. AASC provides information, relief and hope and reduces isolation. Once there has been a diagnosis, there is no point in worrying about how you got it—the fact is that the disease is present and victims have to deal with it in the best way that they can. To quote someone who suffered from mesothelioma: 'it is what it is'.

[98] **Mr Whitston:** For most of my working life, I was a bricklayer in the construction industry and I have lost good friends to mesothelioma. However, for the last 10 years, I have been co-ordinator of the Greater Manchester Asbestos Victims Support Group and chair of

the Asbestos Victims Support Groups Forum, which consists of asbestos support groups throughout the country, mainly in large conurbations, but also near dockyards and shipyards. All of our groups spend their days visiting asbestos victims. In Greater Manchester, I saw 130 mesothelioma sufferers last year.

[99] My colleague Marie has explained that we have roughly the same population in Greater Manchester as you do in Wales. The blight that Greater Manchester suffers from is quite horrendous because, almost every day, I go to see someone with an asbestos-related disease, but certainly two to three times a week, I see someone with mesothelioma. It is a daunting prospect to walk up a garden path and go into a house where life has changed inexorably—nothing will ever be the same again. They are stunned and shocked by a diagnosis and prognosis that has taken away virtually all their hope. We follow their journey through the minefield of benefits and revisit when necessary.

[100] Essentially, our work is largely taken up with daily contact with people. Our group, as other groups, also runs a mesothelioma support group. In Manchester, that is a very lively group, mostly of widows. We had a meeting yesterday where there were 25 and their main purpose is to work to make things better for those who suffer from mesothelioma now and who will suffer from it in the future. From our perspective, we very much welcome this draft Bill and it is our hope that sometime in the future it may be successful.

[101] **Ms Hughes:** Bore da. Fy enw i yw Marie Hughes ac rwy'n dod o Wrecsam yng ngogledd Cymru. Gan fod Tony yn Sais, rwyf am siarad trwy gyfrwng y Saesneg.

Ms Hughes: Good morning. My name is Marie Hughes and I come from Wrexham in north Wales. As Tony is English, I wish to speak through the medium of English.

[102] I was just explaining that I am going to speak through the medium of English.

[103] My husband died of mesothelioma in 2005. He was a retired headmaster, but had worked in the steel industry in the late 1960s and early 1970s. He was very fit; he was a runner and he discovered that he was losing 30 seconds on the mile, which was the first indicator that there was something medically wrong with him.

[104] He was sent to Liverpool and had a thoracotomy, which is quite an invasive procedure, where a large incision is made in the back, from which samples are taken. That can only prove that you have mesothelioma and not that you do not have it because they simply take out some cells and find some rogue cells to confirm their fear. Sadly, the outcome was that my husband had mesothelioma. At the time, he was told to get on with his life as there was nothing that could be done for him.

[105] After that, a trial was held for the drug, Alimta, which at that time was not licensed by the National Institute for Health and Clinical Excellence, but it is now. He was given a trial of Alimta, which is a form of chemotherapy, which is usually given with cisplatin or carboplatin. It makes the person very ill, but the hope is that they will eventually improve.

10.15 a.m.

[106] Due to the fact that the tumours shrank slightly, they then offered my husband an extrapleural pneumonectomy—a procedure that they do not offer now. It was a very basic principle—which involved the removal of a whole lung, half the diaphragm and half the pericardium—of removing the tissue and slowing the progress. It was as basic as that. That procedure was carried out in Leicester. It meant that he was in that hospital for six weeks and so was I. Wrexham to Leicester, as you can imagine, is not an easy journey, so I stayed there with him for six weeks. After that procedure, his quality of life went down radically, but I can remember that when we were first offered that procedure, we were not pressured into it. We

were—strange as it may seem—high as kites coming from the consultation, having been told that suddenly there was a procedure and we could be proactive and do something. My husband went into that procedure with his eyes wide open and said that, in years to come, they would refer to this as 'the butcher's way out'. Those were his words, not mine, and, sadly, that has been the case.

[107] He was offered further chemotherapy—again, Alimta, which was still on its trial at that point. We noticed then that it was affecting his mobility and that, sadly, tumours were now occurring on his spine. By March 2005, my husband was paralysed from the chest down and all this while he was fighting to breathe—he was down to one lung. I was able to have him at home for all that time and we had all the practical help in the way of hoists and what have you, and up until the last four days he remained at home.

[108] Alas, Phil's treatment was not the success we had hoped for, but it was a form of research in that we know what works and what does not work so well now. It was a situation that was brought about not by the ignorance of his employers, but by negligence—they did know that those regulations were in force and liability has been admitted. I would like to think that what he went through will be a positive way forward for other sufferers. I cannot change my lot, but, hopefully, it can improve the lot of people ahead of me. It was in the steel industry—Brymbo steelworks—that my husband contracted it. It was called GKN when he was there, which then became British Steel and Corus and, of course, it is now Tata, and you have your south Wales connections with it now. Thank you.

[109] **Mark Drakeford:** Diolch yn fawr iawn am rannu eich profiadau gyda ni y bore yma. Rydym yn ei werthfawrogi pan mae pobl yn dod mewn ac yn siarad am bethau personol fel yna; mae'n help mawr i ni fel pwyllgor.

Mark Drakeford: Thank you very much for sharing your experiences with us this morning. We greatly appreciate it when people come in to talk about personal issues like that; it does assist us very much as a committee.

[110] We will move on to questions from committee members. As you know, our job at this stage is to consider the Bill that has been put before the Assembly by Mick Antoniw, with the support of Vaughan Gething. Our job at this stage is to consider whether we think that the basic principles of the Bill are sound and whether we would recommend to the Assembly that it should move to the next stage, which is when a Bill, if it succeeds at Stage 1, is looked at in detail. Committee members are likely to have questions for you about the basic purpose of the Bill, what it seeks to do, how it goes about the job that it sets itself and so on. I will just see who would like to go first.

[111] **Kirsty Williams:** I asked this question of the Members in charge earlier. Some concerns have been raised that because there might be additional liability for the companies involved if they have to pay back the costs of NHS care, that might make it more difficult for a family to receive a final settlement—that is, for example, they might argue longer. Do you have any concerns that that would be the case? There is another question that I asked this morning. You will be aware that, as the law is currently drafted, once the claim has been settled, that will be the end of the recovery of costs for the NHS; so, it is costs up until that point rather than costs further on in the process. Do you think that that is the right way to proceed, or do you think that we could change the Bill so that we could have a more complete opportunity to recover all the costs incurred by the NHS?

[112] **Mr Whitston:** Perhaps I could address your first question at a tangent. In 2008, there was a mesothelioma summit where the Government of the day had decided to recover the Government lump sums for itself, rather than letting the insurers reduce their compensation. It was a windfall to the Government. It was astounding that, at the summit, the insurers said, 'In that case, we will have to put up the premiums and it will affect the employers'. When I heard

that, I thought, 'This is just crying wolf, and this is what happens every time'. I believe that, in this case, with your proposed Bill, the same mantra is coming out. In fact, employers must have employers' liability insurance, and it is the insurance that will cover them. It is up to the insurance industry to put that level of insurance at the appropriate amount and to look forward to future liabilities and gauge that cost appropriately. As it is catastrophic insurance, it is to prevent an employer from going under as a result of something that might happen in a catastrophic way. Therefore, I do not accept that argument; I do not think that it is well-founded in any sense.

[113] **Kirsty Williams:** Sometimes, politicians pass laws with the best of intentions, but when that law begins to take place you find that there are unforeseen consequences to what you have done that might be harmful. I am just worried that we might pass a law that will make it harder for individual families to settle a claim: the insurance companies will battle even harder because they will be liable for more costs. I do not want to do something, thinking that it will help the situation, only to find that, when the law actually takes place, we have made it harder for individual families at the beginning of the process, rather than having dealt with what this law is supposed to deal with, which is the end of the process and just the NHS side. We do not want to make it difficult for families.

[114] **Ms Barnes-Mannings:** From a family's point of view, when sat in the office of a consultant who is about to tell you that you are about to lose the person that you love more than anyone else in the world, the very last thing on your mind is money. The very first concern that you have is their care, their nursing care, their treatment, and their support. That is my point of view, having been through that. However, I am confident that the families that we speak to, after the point of diagnosis and throughout their journey, reflect similar concerns. The first priority is their health and their care.

[115] **Mr Whitston:** I would like to come back on the point that you made, Chair. I spoke to a solicitor in south Wales the day before yesterday because I was keen to see the feelings in Wales. He raised the point that you mentioned. He said that, because the insurers might incur extra liabilities, they may be more reluctant to settle. This is a concern. However, we find that, indisputably, every single year, mesothelioma payments have been challenged in the courts by insurers and employers in one way or another to limit liability. It has been a war of attrition, and it will never end until mesothelioma stops in around 2014. It will not end. There is always the risk that they will make it more difficult. It is already difficult; they are already making it difficult. If we were to take them to account, it means that we would retreat behind the barricades at every stage, and never try to improve things or make changes for society at large. I think that the overriding principles that underpin this Bill are, perhaps, more important than what might be some temporary difficulties—God knows that the families face enough already.

[116] **Rebecca Evans:** I would like to look at how the Government should best use the funds that it recovers. The explanatory memorandum to the Bill says that the Welsh Ministers must have regard to the desirability of using the money received for the purposes of treatment of, or other services relating to, asbestos-related diseases. How do you think that the moneys recovered could be best used to support people affected by asbestos-related diseases and their families?

[117] **Ms Barnes-Mannings:** From AASC's point of view, we would refer you to point 14 in our statement. In the feedback, as I mentioned earlier, there was very much a feeling of isolation and abandonment and limited knowledge and awareness of the disease. The problem that we found, and it has been echoed by the families that we have been speaking to, is that there seems to be a cut-off point—a point at which we felt that we were to go home and wait for Dad to die. Speaking to a family this week, the aspect of our service that they seem to value the most is that we provide regular follow up. We stay in touch with them throughout

their journey. We know that the nature of the illness means that their symptoms will change and can change quite rapidly quite suddenly. Perhaps they do not want to think about what lies ahead, and it may not be certain, but through that regular contact, we can signpost accordingly to the best services. The feedback that we have had is, 'Wouldn't it have been lovely to have had that regular contact from the nursing or the healthcare professionals so that they could advise us on the shocking symptoms that we were seeing and experiencing?' They would have had a reassurance from their healthcare professionals. An assumption is made that the next of kin will automatically become the carer, and that is across the board, but when you are dealing with a disease that is as aggressive as mesothelioma and have limited knowledge, some carers feel lost. I never had any training or guidance on how to lift a patient with bedsores or any indication of how the disease might progress.

[118] So, in answer to your question, a helpline, as we detail in our statement, would be good as would more one-to-one interaction throughout the journey with healthcare professionals, because, at the moment, it is clear that the NHS is stretched and there may not be the time and resources, and that came through to us as a family.

[119] **Ms Johns:** In terms of the services that are available in Wales, particularly from the NHS, we have found that we are well endowed with specialist nurses, lung cancer nurses and respiratory nurses and, fortunately, we now have a meso nurse based in Cardiff. However, unfortunately, we have regional disparities. We have found that good care may be received in south Wales, but then in west Wales, if you travel up the coast, go through Powys and up to north Wales, you get the usual discrepancies in care. So, should any compensation be successfully obtained, I would like to see us enhance the skills that nurses and the medical profession already have and try to improve our connection with and the support that we give professionals throughout Wales, because we are finding that there is a gap. It is not just in mesothelioma or asbestos-related diseases. So, we would like to see it used to strengthen, enhance, support and give confidence to healthcare providers and to other members of the third sector who are giving support to victims. We have carers' support groups out there as well. We provide a signposting service and we know that people are out there, but we sometimes need that little bit of extra finance to make sure that we can provide education and training sessions. Wales can get it right, and we have skilled people out there, but, sometimes, we need that little bit extra to make sure that we can enhance those skills.

[120] **Ms Hughes:** I cannot comment on what is in north Wales now, because my case was in 2003 to 2005, and there was very little at that point. Equally, the greater Manchester group was in its infancy at that time. In fact, it had not happened by the time my husband had died, and things have moved on since.

10.30 a.m.

[121] It is research that I know the greater Manchester group feels very strongly about. At the moment there are two research funds. The Mick Knighton Mesothelioma Research Fund was created in 2002 by a widow who, in her words, was bloody-minded. Her husband had worked for the Ministry of Defence, and the Crown cannot be taken issue with over this, yet it did admit liability, and she said that, out of bloody-mindedness, she would raise £100,000. Her friends thought that she was mad, but by 2011 she had actually raised £1 million towards mesothelioma research. Equally, the June Hancock Mesothelioma Research Fund founded in 1997 has raised £1.1 million. Both those charities were created through the loss of loved ones to mesothelioma. The greater Manchester group, through its annual events for the Action on Mesothelioma Day, has generated funds in excess of £110,000 that it has donated to these two charities. This is coming from families—not all of it, but they are great contributors to these funds. If this Bill succeeds in providing finance, would it not be just and fair for those moneys to come from that coffer, because a lot of it is coming from people who are already suffering out there? Research would be a positive way forward to hopefully alleviate this pain and

suffering that families go through.

[122] **Mark Drakeford:** I am sorry but, because we are already two thirds of the way through our session and I have a number of Members who want to ask questions, I will just summarise what I think your position on Rebecca's question is. I think I am right in saying that, were there to be money recovered in the way the Bill suggests, you say that there is no shortage of purposes, either in services or research, for the money to be applied to in order to improve the position of people who suffer from these conditions. I think that that is probably a fair summary of the position.

[123] I will go to Lindsay, Julie and Darren in the next quarter of an hour, so I appeal for reasonably short questions and answers.

[124] **Lindsay Whittle:** Good morning, all, and thank you for your extremely powerful evidence; It was almost a bit too much for me at one point. I am sure that your loved ones would be very proud of your fight and the stance that you are taking in their memory, and it is heart-warming to hear. Tony, you mentioned your concern that this would be a solicitor's charter, and, having questioned the Assembly Members, who are both solicitors, I can really assure you that they have good intentions. What is the experience of sufferers when they have to fight for compensation? I have a sneaking suspicion that this will now add weight to the insurance companies, who will bring in more powerful barristers and solicitors to fight against the ordinary person, and that will increase the costs. I wondered what your experience of that was. How did you manage to support those people?

[125] **Mr Whitston:** You go to the heart of the matter in many ways, and it is a reasonable concern. Mesothelioma sufferers have very little time, and quite a lot of the claims are carried on after someone has died. That is despite Senior Master Whitaker at the Royal Courts of Justice, who has brought in expedited procedures through his practice direction, but many people still die before claims are settled. So families would like to see quicker, better procedures for claims, and it is true to say that things could be vastly improved in that way, and it would make the cost of claims cheaper. There is much that can be done to reduce the costs. You are quite right that the insurance industry will not take kindly to this Bill. It will see an extra burden of cost to itself, so it might be more minded to fight a case that it would not previously have fought. This is the reality.

[126] On the other hand, we know that, at the moment, there are endeavours to make the mesothelioma claims procedure swifter, faster and better. If those endeavours continue, then we can make real changes to relieve the stress of taking on a claim. I will say this: in my experience—and I have a lot of experience, unfortunately—an awful lot of people never make a claim because it is too stressful. They are facing imminent death. They are frightened of lawyers; they are working-class people who do not take to claims and are not litigious in any sense of the word. All the barriers are against their taking a claim, and of those that do, it is often the widows and the family left behind who do it, because they are so angry about what has happened.

[127] I do not have the statistics for you on this, but it is my feeling that the families would say that this is a just and reasonable thing to do. I cannot say that, in all circumstances, it will not make it harder, and none of us wants to make it harder, but in the round, I think that it is a judgment that has to be made. I have made mine, and those I have spoken to are in general agreement. I do appreciate, however, that Members of the National Assembly will have to weigh this up. My opinion, however, is that, in the round, it would be better for society at large to see this go forward and, at the same time, I would urge the members of all political communities throughout UK to look at measures to reduce the cost of litigation in order to ensure access to justice. We are not concerned about lawyers' fees or how they get on; we are just concerned about a good system and a just system. I beg you to consider it in the round.

[128] **Julie Morgan:** You obviously do a great job in terms of the particular disease that you are working with. Do you think that this sort of Bill should be extended to other diseases where compensation is paid?

[129] **Mr Whitston:** I think it logical that it should. My understanding is that costs are recovered for injuries, and I do not accept or think that there is any value in the arguments of those who have said that this is not appropriate for diseases per se. The reality, however, is that, for occupational diseases, because of the tremendous difficulty of proving liability, or proving occupational causation, you would not as far as I understand it be looking at a great deal of people for whom you could recover costs in respect of their claims. Asbestos is different, especially with mesothelioma, in that the only main cause is exposure to asbestos, and everybody knows the terrible legacy of that. It seems incredibly difficult to understand why diseases do not logically follow injuries, with the same principles applied to them. If it is the case with asbestos diseases, then I think it logical that other diseases should follow. However, as far as I understand it—and you can get far better evidence than mine—it would not extend terribly far, because of the difficult nature of determining occupational diseases. But, yes, I think that it would be logical.

[130] **Darren Millar:** I want to ask about the costs that can be reclaimed on behalf of the NHS. The Bill, as originally set out, was designed to recover the costs in both primary and secondary care, but the committee was told this morning that primary care is now being excluded from the costs that can be recovered on behalf of the Welsh NHS. Listening to your story, Mrs Hughes, I heard you refer to caring for your husband at home, and it seemed to me that there may be quite significant costs to the NHS associated with that care, in providing support—

[131] **Ms Hughes:** There were not, because I did most—[*Inaudible.*]—primary care, and a palliative doctor did visit a couple of times towards the end. This was not because it was not there, but that we chose not to take it up. He told me that he had provided every possible gizmo to help in the home, but he also said, 'We're not giving you additional help'. I asked my husband if he was happy for me to do all the care, and he said that he was, and the comment of the palliative doctor was, 'I know where you are coming from; you can feel as if the world and his wife are in your home, but, on the other hand, you're probably breaking every rule in the Geneva convention as regards to working conditions over it'.

[132] To go on to your point about cost, I looked through the tariff that was cited in the Bill, and I simply took account of the amount of overnight stays that my husband had had. That is all that I itemised; I did not itemise the out-patient visits, radiotherapy treatment or any of the medications. The in-patient stays alone, based on your tariff scheme, would have hit £50,000, because it is £719 a night, and I worked out how many nights my husband had been in hospital.

[133] **Darren Millar:** In terms of primary care, do you think that it is sensible to exclude the costs of primary care from the recovery scheme? Given the way that technology is advancing these days, it seems to me that some of the care provided to your husband and other sufferers in hospital in the past might well be able to be provided in the home in the future. Do you think that this ought to be future-proofed by allowing those primary care costs to be recovered as well?

[134] **Ms Johns:** The Bill is complex as it is. In terms of making claims for care that is provided in the home, I am sure that you will all be aware that we are very fortunate to have hospice at home services, many of which are non-NHS services. Hospice at home services can make the claim, as you know. I know from Jo's personal experience that claims were made in that regard. However, while I would not suggest not making a claim for primary care,

I would like to see one step at a time. I think that one should see how this works with regard to making claims for NHS care in an in-house setting before the next stage, which is care provided directly in the home, because, sometimes, if something becomes too complex you will come up against an even bigger brick wall. However, that is not to say that it would not be possible to make claims for care in the home in the future, because the nature of the way in which care is going means that more and more care will be delivered in the home.

[135] **Darren Millar:** Do you think that it would be sensible, therefore, to allow for a mechanism in the Bill that would enable the extension of the scheme in order to recover primary care costs in the future?

[136] **Ms Johns:** Well, it is working for the hospice at home services at the moment.

[137] **Darren Millar:** So, you think that it would be entirely possible to recover those costs?

[138] **Ms Johns:** Bearing in mind that it is complex, yes.

[139] **Mark Drakeford:** I want to ask one final question, probably. To follow up on the very full answers that you gave to Rebecca about the purposes that any money recovered could be put to, the Bill, however, sets up a relatively weak link between the money collected and what it will be used for. The money will be put in the hands of Welsh Ministers and they will then decide what to do with it. In our session with the Member in charge, Elin Jones suggested a way in which the accountability of Ministers to report on what they use the money for could be strengthened, so that people would have greater confidence that the money coming in was being used for some of the purposes that you described earlier. Are you satisfied that the Bill makes a strong enough link between the money collected and the purpose that it will be used for, or do you think that we as a committee should continue to explore ways in which that link might be strengthened?

[140] **Ms Johns:** For the sake of transparency, to strengthen accountability for how the money is spent would be advisable.

[141] **Elin Jones:** For example, I mentioned to the proposer of the Bill this morning that he could consider putting something in section 16, which says that the Welsh Minister must have regard to the desirability of how the money is spent, to specify that the Welsh Minister should make an annual report to the National Assembly, which would be publicly available, on how that money has been spent in the preceding year.

[142] **Ms Johns:** That sounds positive, because in so doing you are raising the profile of the nature of mesothelioma and asbestos-related diseases, so I would see that as a positive move forward.

10.45 a.m.

[143] **Mr Whitston:** I think that it is important to have a review of the effectiveness and use of the money so that we do not see a situation where it is not being used in the best way, perhaps. It would also be useful in Wales to talk to the people who are benefiting from it and to get that feedback. So, you are right that there are tremendous opportunities, if the money is coming forward, for it to be used in the best possible way.

[144] **Mark Drakeford:** Diolch yn fawr iawn i chi i gyd am ein helpu y bore yma.

Mark Drakeford: Thank you very much for helping us this morning.

[145] It has been very useful for us as a committee to be able to share some of the insights

that you can provide as people who work directly with these issues out there in the field. Thank you very much indeed. Diolch yn fawr.

[146] **Ms Hughes:** Thank you for the opportunity.

10.48 a.m.

Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Sesiwn Dystiolaeth 3
Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Evidence Session 3

[147] **Mark Drakeford:** Awn ymlaen at ein trydydd sesiwn dystiolaeth ar y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru).

Mark Drakeford: We will move on to our third evidence session on the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill.

[148] Bore da a chroeso i Hannah Blythyn, cydgysylltydd ymgyrchoedd a pholisi Uno'r Undeb yng Nghymru a Mike Payne, swyddog rhanbarthol GMB Cymru. Diolch am ddod i'n helpu'r bore yma.

Good morning and welcome to Hannah Blythyn, campaigns and policy co-ordinator for Unite Wales and Mike Payne, regional political officer for GMB Wales. Thank you for coming to help us this morning.

[149] We will start by asking you to offer us a few introductory remarks. It is helpful for us to get an idea from you as to how the work that you do, as unions active in the field, brings you into contact with the issue of asbestos and its costs.

[150] **Mr Payne:** My name is Mike Payne, as you have said, and I am a regional officer with the GMB here in Wales. Our membership currently stands at around 55,000 across Wales, covering all sorts of grades and all industries in Wales. Historically, we have come across Members who have been exposed to asbestos, ranging way back to our members who were boilermakers up to our present day members in schools and so on, which I will go into later on in our supplementary evidence. Our main aim is to support our members where they have been exposed to asbestos and to deal with the support that we can provide through trade union services for legal cover to assist members in taking forward cases where they have been exposed.

[151] **Ms Blythyn:** Unite is one of the largest trade unions in Wales, with about 100,000 members ranging across the public and private sectors, from the more traditional manufacturing and construction industries to things such as voluntary, legal and financial services. To echo much of what Mike said, our unions, along with others, have fought long and hard over the years for justice for our members who have been exposed to asbestos simply through going to work. You will probably be aware of the fact that the Health and Safety Executive reports that most people who develop mesothelioma—the incurable and fatal asbestos-related cancer—are exposed to it through work or at work. We currently have about 11,000 Unite members on our register of exposure to asbestos-related diseases. This is by no means a comprehensive figure, but with regard to the proportion of members in Wales who have been affected, we estimate that approximately 1,100 members are registered in Wales as having been exposed to asbestos.

[152] **Mark Drakeford:** Thank you very much. I will turn to Lindsay Whittle first for the first question.

[153] **Lindsay Whittle:** Good morning—it is nice to see you again, Mike. Clearly, your

members must come to you, as trade union officials, with all sorts of diseases, not just this one. Do you think that this Bill should cover other diseases that affect your members in Wales, or, because these diseases are so specific, and because it can be easily identified that asbestos is the cause, do you think that the Bill should just concentrate on this issue and that there may be scope for another Bill at another time?

[154] **Mr Payne:** This Bill concentrates on a specific issue that the trade unions have been combatting for around 100 years. Our first ever general secretary of the GMB, Will Thorne, raised this issue in the House of Commons way back in 1930. He was concerned about his constituents being exposed to asbestos in the asbestos factories in Barking. It is a long-standing issue on which the trade unions have been supporting members. There is obviously a possibility for the Welsh Government to consider extending this Bill. However, at this moment in time, both the GMB and Unite are supportive of the Bill because it echoes the issue of social justice and is based on the 'polluter pays' principle.

[155] **Rebecca Evans:** On the same issue, are you aware of any other workplace diseases similar to asbestos-related diseases that have such a clear causality as regards the experience in the workplace?

[156] **Mr Payne:** I am not an expert on occupational diseases, but there are clearly a number of different examples that we could give of where people are exposed to particular substances in a particular workplace—the rubber industry was one of those in the past. Similarly, in places where sawdust was an issue, woodworkers have suffered nasal cancer in the past. Those are issues that have been ongoing, and we could expand this Bill considerably. However, as we say, we are of the opinion that this Bill represents a positive move forward and is a positive use of the Assembly's powers to assist the sufferers of asbestos-related diseases in Wales and their families where the sufferers have been negligently exposed to asbestos.

[157] **Ms Blythyn:** As Mike said in his opening statement, with asbestos-related diseases, the cases usually arise from negligence by employers or breaches of health and safety legislation. The industries that have been the backbone of the Welsh economy for decades are the ones in which, primarily and occupationally, our members have been most exposed. For those decades, those employers knew what the risks of asbestos were, along with the insurers.

[158] **Mr Payne:** Based on what we have seen, we believe that the people who have been exposed historically to asbestos can be broken down into three broad groupings. The first group comprises those who were involved in heavy industry in the past, such as boiler-makers, thermal-laggers and strippers. These were individuals who faced high exposure to asbestos. There is a second group of members who worked at a time when asbestos was being phased out over a period. They worked in areas such as building maintenance and construction. They became the second group of exposed people, because the duty to manage asbestos adequately in buildings took time to get established, and people most often encountered asbestos unknowingly, particularly in relation to refurbishment work. There is now a third group, relating to today's exposed occupations, which reflect inadvertent exposure. These are people who work in public buildings such as schools, hospitals and libraries. This exposure is often due to a misunderstanding of management responsibilities in relation to asbestos surveys and record-keeping, which might be down to inadequate training and a general lack of knowledge on the subject of control of asbestos.

[159] We think that this is about those three groupings. Due to the long latency period in the development of asbestos-related diseases, we have seen that the first occupational group has probably passed its peak, in terms of victim numbers. It is now those in the second group, in construction, who are increasingly being diagnosed with asbestos-related diseases. The current evidence, we believe, shows that it is those in the third group who are increasingly

registered as sufferers of those diseases, which is reflected in the change in expectation relating to mesothelioma deaths. They are now not expected to peak in 2015, as was previously suggested, but peaking in something like 2020, and phasing out in something like 2040.

[160] **Mark Drakeford:** Thank you, Mike. That was very interesting. I now bring in Kirsty.

[161] **Kirsty Williams:** While not directly related to the content of the Bill, we have received conflicting evidence that, should this Bill be passed, it could inadvertently lead to it being more difficult for individual families to settle a claim for liability with their previous employers' insurers. The Members in charge said this morning that there was no evidence of that at all. However, the victims and those who campaign on their behalf said this morning that there was a very real possibility that a very tough situation—getting people to admit their liability—would become even tougher because of the additional costs incurred. What is your view on whether this legislation could inadvertently make it more difficult for families to settle compensation claims? In your paper, you refer to

[162] 'attendances to GPs, referral to consultants for radiology ... and in many cases, palliative care'.

[163] As you will be aware, the initial intention of the Bill was to recover all costs. The Bill does not now do that. Given your evidence, do you feel that the Bill should be amended so that all costs incurred by the NHS, whenever an NHS service is received—whether at home or in a primary care setting—would fall under the auspices of recovery?

[164] **Mr Payne:** Maybe I could answer that in two sections. The first point, quite clearly, is that we believe that all medical costs should be recovered. Secondly, with regard to making claims more difficult, the insurance companies have become more vociferous in defending injury claims over the years, whether they are ordinary injury claims or claims for asbestos-related diseases. We are not seeing anything specific targeted at those individuals who suffer from asbestos-related diseases. They have evolved that way. We personally think that insurance companies should not be allowed to negate their responsibilities to those individuals who have been exposed negligently to this type of material. Therefore, that is why we are here today to support the Bill in its entirety.

11.00 a.m.

[165] **Kirsty Williams:** I am sure that there is a great deal of support for the Bill. However, we would not want to do something here that would make it harder for individual victims' families to receive a settlement. The Bill does not address that, but it could have consequences for that process. I am asking whether you think that it might. The victims' families think that it is a price worth paying. Yes; it will make it more difficult, but, in the round, it is a price that is worth paying to go forward on this basis. The evidence that we had from the Member in charge—or his supporter—is that it will not make any difference to the process. As people who do this on a daily basis, I am interested to know whether you perceive that we could make things tougher but that it is a price that is worth paying; whether you do not think that it will make any difference; or that it will make things tougher and that it is not a price that is worth paying. I am interested to hear your view on that.

[166] **Ms Blythyn:** As trade unions, we have been there over the years to support our members with their claims to negligent employers. I think that you have got it right in that the commercial interest of the insurers should not be put ahead of the principles of social justice that are outlined in this Bill.

[167] **Mr Payne:** We believe that it could be more difficult, but, as you have heard, from the point of diagnosis, sufferers from this disease, in most cases, pass away within 12 to 18 months. So, their cases go on way past the time that they pass away. That is why the trade unions are here to support the individuals through the legal system and provide our members with legal benefits to be able to fight these cases for as long as it takes.

[168] **Mark Drakeford:** Thank you, Kirsty. I now call on Julie.

[169] **Julie Morgan:** Thank you. Good morning. In response to Kirsty, you said, Mike, that you felt that all medical costs should be recovered. However, in that respect, the Bill does not cover all medical costs. Could you give your view on why you think that the Bill does not cover all of the medical costs, and whether that makes it less effective?

[170] **Mr Payne:** We have mentioned in our paper that we are supportive of the 'polluter pays' principle. The fact is that if someone is negligently exposed to this type of material and they suffer consequences from that, the people responsible for that exposure should pay the full costs. On that basis, as trade unions, we would support the principle that all costs are covered. Unfortunately, the Bill as it currently stands does not specify that, but we, as trade unions, will continue to campaign for that to be the case.

[171] **Julie Morgan:** So, you think that the Bill should be improved.

[172] **Mr Payne:** I believe so. That is my personal point of view.

[173] **Ms Blythyn:** I would agree with that.

[174] **Julie Morgan:** As trade unions, have you been involved in the preparation of the Bill? Have you worked with the proposers at all?

[175] **Mr Payne:** We have been asked for advice and to give a view on the Bill, but I have not been involved in the fine detail.

[176] **Ms Blythyn:** We submitted to the initial consultation on the Bill as well.

[177] **Julie Morgan:** Have you discussed the Bill with your members?

[178] **Mr Payne:** Our members have been consulted by our senior representatives and activists across Wales; hence the reason why I am able to sit here today and say to you that the regional position, with regard to this Bill, is that we are supportive of the underlying principles of social justice contained within the Bill and the use of Assembly powers to bring it about.

[179] **Ms Blythyn:** To build on what Mike said earlier about this being a very good example of the Assembly using powers for a purpose, it is a very good example for us to use when we speak to our members about how devolution is making a direct difference to working people in Wales.

[180] **Mark Drakeford:** We asked our previous set of witnesses whether there were gaps in current provision that they could see from the work that they did, and that if money were to be recovered in this way, that money could be used to bolster provision for people who find themselves in this position. Given the work that you do with individuals, is there anything that you wish to say on that? In your experience, are there purposes that this money could be put to that would help people who are in this position?

[181] **Mr Payne:** Obviously, the asbestos support groups would ask for greater resources

for research, which we would very much support. We would also support the opportunity for greater support for families of sufferers across Wales, and the ability to look at doing away with what is a postcode lottery of services across Wales and to invest in services that make that more uniform so that, depending on where you are in Wales, you are able to access specialist advice and support. It should not be right that if you live in Cardiff you have access to specialists, whereas in another part of Wales you do not. That specialist advice and support should be used to benefit everyone in Wales, wherever they live.

[182] **Ms Blythyn:** While the suffering of an individual who is the victim of asbestos-related diseases is what is meant here, what is often overlooked is the suffering of the immediate family. So, you could build on what the support groups said and ensure that there is better provision of services and more comprehensive support services for the families.

[183] **Elin Jones:** Building on that, the Bill, as written at the moment, is really pretty weak about how transparent and accountable the Welsh Minister would be with regard to how the recovered money would be spent. Do you have a view on how that could be strengthened? One option would be that the legislation could state that the Minister would have to report annually on how recovered moneys have been spent by Welsh Ministers and the Welsh Government to aid that transparency. Would you welcome that kind of approach in principle?

[184] **Ms Blythyn:** That sounds like a sensible idea.

[185] **Mr Payne:** We would very much support that idea; it would allow for an ongoing review process and it would allow us to promote awareness of the effects of the disease. It would also give us opportunities to signpost people towards support. We would therefore welcome that approach.

[186] **Mark Drakeford:** The explanatory memorandum rehearses a number of options for administrative arrangements. It comes down in favour of using the unit at the Department for Work and Pensions. Your evidence supports that. Is there anything that you could tell the committee, just from the more general work that you do as trade unions, and given that there will be other ways in which you come into contact with it, I am sure, about whether that central recovery unit is an effective mechanism?

[187] **Mr Payne:** We believe that this is probably the best and most effective way of being able to recover those costs. It takes away an individual negotiation for every single case, it provides uniformity of impact and allows the Welsh Government to recover costs in the most effective and efficient way available to it.

[188] **Ms Blythyn:** We also believe that the tariff system is the most sensible approach, because it gives the greatest financial return for the lowest implementation cost.

[189] **Mark Drakeford:** The committee is always interested in whether a Bill gets the balance right between those aspects that appear on the face of the Bill and those aspects that are left to regulation-making powers conferred on Ministers. Your evidence specifically states that you think that the Bill has the balance right in this case. I asked the Member in charge of the Bill whether he felt that the appeals mechanism ought not to be in the Bill itself, rather than being left to regulations, and he explained why he thought it was better left to regulations. From a trade union perspective, having sometimes to support members going through an appeals process, do you not feel that having that mechanism set out on the face of the Bill would offer clarity to all those involved in it, or are you content that leaving it to Ministers to flesh out the appeals mechanism through regulations is satisfactory?

[190] **Mr Payne:** We think that the fine detail of this would be better left to Ministers to consider as it develops and as issues arise. To make it too prescriptive could cause problems,

and to leave it without any direction at all could cause major problems. We therefore believe that there is a balance here that allows for flexibility of approach.

[191] **Mark Drakeford:** Thank you very much; that is very helpful. Are there any further questions that anybody would like to raise at this stage? I see that there are none.

[192] Thank you very much indeed for coming to help us today and for the written evidence that you supplied for today's meeting. We are very grateful to you both.

[193] Diolch yn fawr i chi'ch dau. Thank you both.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.09 a.m.
The public part of the meeting ended at 11.09 a.m.

Ailymgynullodd y pwyllgor yn gyhoeddus am 1.33 p.m.
The committee reconvened in public at 1.33 p.m.

Cynlluniau i Ad-drefnu Byrddau Iechyd—Tystiolaeth gan Ddeoniaeth Cymru
Health Board Reconfiguration Plans—Evidence from the Wales Deanery

[194] **Mark Drakeford:** Croeso yn ôl i aelodau'r pwyllgor a'r tystion sydd gyda ni am sesiwn gyntaf y prynhawn yma. Rydym yn bwrw ymlaen ag eitem 9 ar yr agenda, ar y cynlluniau i ad-drefnu'r byrddau iechyd. Trefnodd y pwyllgor drafod y pwnc hwn yn ôl cyn y Nadolig, ond heddiw, byddwn yn cymryd tystiolaeth gan Ddeoniaeth Cymru. Diolch i chi sydd wedi dod i'n helpu heddiw, yr Athro Derek Gallen, deon ôl-raddedigion, yr Athro Peter Donnelly, dirprwy ddeon ôl-raddedigion, Dr Jeremy Gasson, arweinydd ad-drefnu gwasanaethau obstetreg a gynaecoleg, a Dr Helen Fardy, arweinydd ad-drefnu gwasanaethau pediatrig.

Mark Drakeford: Welcome back to committee members and to the witnesses joining us for this afternoon's first session. We will now proceed to item 9 on the agenda, concerning the health board reconfiguration plans. The committee arranged to discuss this subject back before Christmas, but today, we shall take evidence from the Wales Deanery. Thank you for coming to assist us this afternoon, Professor Derek Gallen, the postgraduate dean, Professor Peter Donnelly, the deputy postgraduate dean, Dr Jeremy Gasson, the reconfiguration lead for obstetrics and gynaecology, and Dr Helen Fardy, the reconfiguration lead for paediatrics.

[195] Fel arfer, gofynnwn i aelod o'r panel ddechrau drwy wneud unrhyw sylwadau agoriadol byr sydd ganddynt. Rydym wedi derbyn y dystiolaeth ysgrifenedig; diolch yn fawr am honno. Ar ôl clywed y sylwadau agoriadol, byddaf yn troi at aelodau'r pwyllgor yn syth i ofyn cwestiynau.

Our usual practice is to ask one member of the panel to start us off by making any brief opening remarks they may have. We have received your written evidence; thank you for that. When we have heard your opening comments, I will turn immediately to committee members for their questions.

[196] I am not sure whether you have decided who will open. I see it will be Professor Gallen. The microphones will come on automatically. You do not need to do anything.

[197] **Professor Gallen:** Thank you for inviting us to come today and give evidence. We are the postgraduate deanery for all of Wales. We train approximately 2,700 doctors and dentists across all of Wales. We are funded by the Welsh Government and the General Medical Council. The UK body is the body that sets the standards for training across the UK and we very much answer to those standards and to the GMC with regard to the quality of the

training that we provide here in Wales.

[198] **Mark Drakeford:** Thank you. We will go straight into questions. Darren is first.

[199] **Darren Millar:** Thank you for your paper, which was very helpful and informative. We have met in the past, Peter, and that was a useful meeting. You are obviously funded by the Welsh Government. Has your funding been consistent over the past few years, or has it been declining in real terms? Does that have an impact on the number of training posts available in Wales?

[200] **Professor Gallen:** The funding has been cut over the last few years, so we have seen a reduction. It has had no impact on the number of trainees that we are able to recruit and train in Wales. It mostly affects our infrastructure costs within the deanery—that is where we have seen the major reductions. So, I cannot say that, because of the funding, we are getting fewer doctors. It is not true.

[201] **Darren Millar:** To what extent has the reduction in funding had an impact on the deanery in terms of what you are able to deliver?

[202] **Professor Gallen:** It has had an impact on the number of staff that we have delivering the systems within the deanery. We have fewer members of staff now, and we have had problems with recruiting staff members because of the reduction in the funding and our ability to access it. That has been the major thing, but, as I say, the funding stream for trainees is slightly separate within our budget.

[203] **Darren Millar:** How much is that funding stream for trainees?

[204] **Professor Gallen:** Approximately £70 million.

[205] **Darren Millar:** Has that been going up, down or flatlining?

[206] **Professor Gallen:** It has been flat.

[207] **Darren Millar:** Surely the costs of delivering training must have increased.

[208] **Professor Gallen:** They have, but because of our recruitment issues we almost get a saving each year, because we are not able to get every single person whom we could possibly train.

[209] **Darren Millar:** You refer in your paper to around 2,700 doctors being in training, and there are 330 dental trainees at the moment. How does that compare with previous years—the past three, four or five years?

[210] **Professor Gallen:** It is pretty flat. There has been very little difference over the years. We have had problems recruiting to some specialties, but those specialties can change, so the overall number tends to be roughly the same. The specialties that we have problems with can change.

[211] **Darren Millar:** We are told on a regular basis by local health boards that one of their big challenges is recruitment, and that the number of trainees available in different areas has an impact on service sustainability at times because of their availability on rotas, etc. If you had more funds available in order to deliver more training places, what impact would that have on the Welsh NHS in terms of ability to cover rotas, et cetera?

[212] **Professor Gallen:** There are a few issues there. One is that our business is about

training people, not service delivery. Clearly, there is a tension between service delivery and education, because our people are based in the workplace. If we had unlimited funds we would still, I suggest, have problems with certain geographical areas in Wales, which are just not attractive to junior doctors. We have highlighted that within our written submission.

[213] **Darren Millar:** If you did have more resources, however, would you create extra training posts?

[214] **Professor Gallen:** We could create extra training posts, but with regard to the specialties that we are currently having problems recruiting to—paediatrics, psychiatry and emergency medicine—the rest of the UK also has a problem recruiting to them. Money is not the answer for those three specialties. The market is not there for them, so it is not about whether we can have any more money. We cannot fill the posts, so it is not about a money shortage for us; people just do not wish to undertake those specialties.

[215] **Darren Millar:** You have sort of referred to this in your paper, but I am still not quite sure why this is the case. Why is it unattractive to come to Wales compared with England, for example? Is there a differential in terms of trainee doctor pay, or is it the rota system that we have that moves people from north to south, from east to west and cross-border?

[216] **Professor Gallen:** The geography is an issue, because trainees like to be fixed in places. We have a tertiary centre, which is Cardiff, obviously. The curriculum for some of the specialities demands that trainees rotate through the tertiary centre to get specific expertise and people in north Wales do not particularly want to come down to south Wales, hence our reason for linking in with the Mersey deanery to provide that tertiary centre there so that they can stay there.

[217] When people apply to Wales, they are quite concerned as to which bit of Wales they will end up in, and where they might rotate or have to rotate to subsequently. If you are in a single deanery in England, for example, you know that that is your geographical area. We have to be a whole country as a deanery, and it is not quite the same for England.

[218] **Darren Millar:** In terms of the working links on a cross-border basis, are you satisfied that they are sufficiently robust to not cause a recruitment difficultly for you? It is not compounding the recruitment issue, is it?

[219] **Professor Gallen:** I do not think that it is compounding it, no.

[220] **Mark Drakeford:** Mick is next, then Kirsty.

[221] **Mick Antoniw:** I found the paper to be very helpful. I just have a couple of points that I would like to clarify and I have one or two key questions to ask you. You refer in the paper to a number of initiatives with regard to retention. For example, you refer to reducing the number of fixed-term positions in some specialities. On what basis are there fixed-term positions, and why do we still have them as opposed to permanent positions?

[222] **Professor Gallen:** The Modernising Medical Careers programme, which came in in 2005, had a series of jobs called ‘fixed-term training slots’, and they were only for a maximum of two years. So, the landscape of postgraduate education changed at that time. Historically in Wales, and we refer to this in the paper, we had a great many senior house office doctors who found themselves in these fixed-term slots. However, they are not attractive posts, because by definition they end and you are not in run-through training, so you are not in a bona fide training slot. We have reduced the numbers of those in virtually every specialty across Wales. That in itself makes Wales more attractive since we do not have those positions anymore.

[223] We have also increased the number of our training slots—we did not just take out the fixed-term positions, but increased our training slots—which makes our competition ratios much better. That is the sort of information that trainees look for on the web, so that they can see what their chances are of progressing. If there are very little or virtually no fixed-term slots, they have a much better opportunity.

[224] **Mick Antoniw:** To get some clarity on what you are saying, you refer in your paper to a certain amount of confusion about where Wales is, language and a number of issues there. Is the marketing of trainee positions co-ordinated as a national and collective issue, or is it done locally by local health boards, or whomever? How does that happen, because it is surprising that some of those examples that you have given are issues?

[225] **Professor Donnelly:** Perhaps I could pick up on that. Most specialties across the UK have moved to UK national recruitment, so the advertising of most specialties within Wales would be done within that national recruitment process. In parallel with that, our careers unit works in a collaborative fashion with NHS Wales, the Welsh Government and the Welsh NHS Confederation in attending careers fairs, et cetera, in order to market the current product, which is the current situation in terms of the training experiences. So, it is a multi-faceted aspect on a UK national level and a Wales perspective as well.

1.45 p.m.

[226] **Mick Antoniw:** Thank you. There are other questions that I want to ask on that, but I will move on because of the time; I know that others have questions they want to ask. Within the paper, one of the issues that was regularly raised was the actual catchment areas of the health boards, the size of them and the number of, for example, different types of specialist operations in a particular specialism that will be coming through, and the impact that has on training, in terms of whether training posts can be authorised on the grounds that it is not suitable for training because you will not get the consistency of experience. Is that a major issue? It is not mentioned in your paper, other than indirectly, yet when I have had discussions, that has been one of the major issues that has been raised.

[227] **Professor Gallen:** Yes, it is an issue. Some of the curriculum demands that the trainees have a certain level of exposure. I do not know if Jeremy wants to talk about obstetrics and gynaecology as the most pertinent one.

[228] **Dr Gasson:** Our college suggests that if you are going to have trainees working outside normal working hours, outside 9 a.m. to 5 p.m. Monday to Friday, the units delivering less than 2,500 births would be perhaps not providing enough experience for those trainees: they will not get much from working those out-of-hour shifts. Our specialty is a little bit different because we have the very acute labour ward obstetric stuff and then we have the very cold gynaecological stuff, and there is a bit of acute gynaecology as well, so not only do we have to look at how we cover out-of-hours provision, but we have to ensure that those trainees have obtained the cold, surgical experience and the out-patient experience that they require as the other half of their training. The difficulty that we have with some of our rotas is that most of our rotas are somewhere between one in six and eight, but not all hospitals are filled, so one in eight may become one in seven or one in six, because they end up covering internally, and those doctors then end up doing more out-of-hours work and less in-hours work and that is their training area that suffers. So, from an obstetric point of view, we do not have any gynaecological mandatory standards, if you like, but we have obstetric mandatory standards, and they would be that, with fewer than 2,500 deliveries, there would be some concern about how much trainees would get from out of hours.

[229] **Mick Antoniw:** In terms of some of the safety and quality issues that you are raising,

particularly within those specialisms, is it the case therefore that, irrespective of all the other factors, you need to have a concentration of those services within larger catchment areas to ensure the quality of training?

[230] **Dr Gasson:** If you had larger birthing units, for example, the complications that arise 1%, 2% or 3% of the time are going to occur more frequently and trainees are going to get more exposure to that and are therefore going to get better at managing those complications.

[231] **Kirsty Williams:** The purpose of your invitation here today was to try to have an understanding of your role within the reconfiguration plans that the country is going through. Quite often, the deanery's name is drawn out as a reason why health boards are doing what they are doing, and when there are changes in services, again, they are often placed at your door. Neath Port Talbot is a classic example, where it was said, 'We've had to do this because the deanery has told us to'. Could you explain to us what your relationship is with the health board and what part you have been playing in the development of its plans? In paragraph 4 of your paper, you state that while you realise that health boards are working to a certain time frame, you believe that training reconfiguration in some specialities is likely to occur ahead of that timescale being set for service reconfiguration. Could you, in layman's terms, explain to the committee what that is likely to mean for services in district general hospitals?

[232] **Professor Gallen:** The first thing to say is that training reconfiguration predates service reconfiguration, so we have been trying to improve the training for everyone in Wales, particularly over the last couple of years. Our approach has been to try to improve the quality of training. We believe that the way to do that is to have more robust rotas, to have our trainees on fewer sites, for some of the reasons that Jeremy has already outlined, and then, hopefully, the professionalising of our educators. We have a whole programme to ensure that our educators are up to speed, which will hopefully improve our exam pass rates. It will make Wales more attractive and more people will wish to come here.

[233] We have worked closely with the health boards. We have a seat on the national clinical forum and on the south Wales programme board for reconfiguration and we meet regularly with Hywel Dda and Betsi Cadwaladr health boards to discuss our views on training in the future. We have been clear to all the health boards that it is not for us to say where the service should be delivered, but that we believe that training would be improved if it were provided on fewer sites with better rotas. So, all the health boards are well aware of that.

[234] On the specific question in paragraph 4, the problem is that we have a serious issue, and I will ask Helen to comment in a second with regard to paediatrics, emergency medicine and psychiatry. This is a UK-wide problem; we are suffering, as is the rest of the UK, but we cannot put paediatricians who are training doctors on every single site in every hospital across Wales because that would not comply with the working time regulations. So, we need to look very seriously, ahead of service changes, at putting our trainees on fewer sites so that they get the proper teaching and training.

[235] **Dr Fardy:** The paediatric programme is particularly difficult to recruit to at present. The health boards are understandably very concerned about the gaps that they have on their registrar tier 2 rotas, which are crucial for rotas and service delivery. In order for us to attract more people to Wales, we need to improve the exam pass rate and in order to do that we need to have trainees on bigger rotas, with more throughput in the units where they are training. We do not meet the royal college recommendations as to what a training unit should have in terms of throughput on a large number of sites where we currently have trainees.

[236] **Kirsty Williams:** What is the timescale? You say that you are not working to the same timescale that service reconfiguration is working to. Could you outline what timescale you are working to and the number of sites that are potentially affected in psychiatry,

emergency medicine and paediatrics?

[237] **Professor Gallen:** It is likely that we will have to make some changes this August, depending on how we get on with the recruitment this year. So, we would see changes to those specialties potentially this August. We do not know what the timescale for service reconfiguration is because it is out to consultation, so we are not quite sure about that. All we have done is signal that we cannot carry on with the current system. So, we have not been able to recruit many trainees in emergency medicine, so most of the health boards are coping without the presence of trainees. In a way, that will make it slightly easier when we come to getting them onto fewer sites and reconfiguring that.

[238] Psychiatry, as a specialty, has to have a complete service reconfiguration within Wales. We have already moved trainees from certain sites because they were not supervised properly out of hours, so we have already done that to some of those sites. On paediatrics, it is likely that, this August, we will see trainees on fewer sites in both Betsi Cadwaladr and Hywel Dda health board areas.

[239] **Kirsty Williams:** Finally, there have been repeated attempts at initiatives by the Welsh Government to address the issue of recruiting more doctors to Wales. The latest one was launched almost a year ago. In your view, have those attempts by Welsh Government to recruit been successful? Do you have any pointers for this committee about what the Welsh Government could do to make these new recruitment initiatives more successful?

[240] **Professor Donnelly:** When you start talking about recruitment and retention in medicine in general, it is a very complex landscape, particularly when one takes into account the demands and expectations of the Y generation. That is the target audience that we are looking for. Also, we are working in a UK and international marketplace. So, in answer to your first question, it is very difficult to gauge because it is not a controlled study in terms of us intervening with a marketing strategy and asking what outcome it has had, because it is so multifaceted. I think that it has been very positive because any positive marketing of Wales, one would say, on face value, is likely to lead those trainees to see Wales in a positive light. I think that we would say that a large-part solution to improving the product, with being a trainee in NHS Wales as the product, is the reconfiguration of training. It is to make those training programmes highly sustainable in going forward, to make them high-quality in terms of their levels of clinical supervision and educational supervision, and to ensure the professionalisation of those supervisors within the NHS. In essence, that is a large part of what we can do in going forward.

[241] **Mark Drakeford:** I will now call on Elin, and then Vaughan and Lindsay.

[242] **Elin Jones:** Thank you for your evidence and for the clarity of your responses so far this afternoon. I want to return to the issue on the reconfiguration proposals of the health boards, and especially the two health boards that are towards the end of their proposals. Those plans will be finalised and released to the public next week. If those two health boards stick to the plans as they have been published in their consultation, they are both talking about three-site models in those two areas. Your advice comes through in the national clinical forum consultation responses, quite clearly advocating fewer sites—and you have said so again today. You have alluded to two sites or possibly a one-site model of training. We could be in a position where the local health boards might continue to plan for a three-site model, but you would be in a position—as you have told us—where you would have to reduce training placements for some specialties in August this year. So, the plans, as they would have envisioned them, would only be sustainable for the next six months. The question that I have for you is: do you have an opinion on whether those health boards can retain those services at sites without training placements and trainee doctors being available on those sites? Are any of those sites sustainable for a period of time without trainee doctors in those specialties?

[243] I have another question on another issue, but perhaps you might wish to answer that one first.

[244] **Professor Gallen:** First and foremost we have to say that our business is still the education of training doctors. We are currently not fulfilling that to the standards required by the General Medical Council or indeed the specialty curricula from the individual colleges. We are not doing that now. We are unable to properly train. That is the reason why we said that we need fewer sites, better rotas, and to professionalise our educators. We have to answer to the GMC for the standards that we deliver, and therefore we will ensure that we provide the best training possible. It is not our business where the service decides it wants to be, but if that health board wishes to have service on three sites, then we have already said to it that we will have trainees on two sites, in the specific example with regard to paediatric services. So, that will happen. On how that health board configures the service on the third site, we feel that it is not our place to comment.

[245] **Elin Jones:** I wish to move on to the issue of GP training that, again, is an issue that the hospital reconfiguration and other health reconfiguration proposals envisage as switching to greater emphasis on primary care, community care and general practice. You and the national clinical forum refer to the tension that will build up because GP training recruitment is an issue that you currently face and you have an ageing population of GPs as well.

2.00 p.m.

[246] Since this is not a problem for the next six months but for the next five to six years, possibly, how do you view the Welsh Government's ability to be more proactive in building up the numbers of possible GP trainees that could be out there? I am thinking in particular of whether you have a view on the linking of a more proactive system of recruitment into medical training or places in education pre-graduation and possibly even financially incentivising postgraduate training in Wales and linking that into working in the NHS in Wales.

[247] **Professor Gallen:** You are absolutely right that the future of service delivery for the NHS in Wales will mean a greater emphasis on care in the community and that we should, therefore, train more general practitioners going forward. We have problems recruiting, but we should strategically align more of our training numbers in the community. That means an alteration to the undergraduate curriculum, where we need to ensure that people fully understand that over half of them will work in the community as opposed to in a secondary care setting. A new curriculum is coming on board in Cardiff that has that greater emphasis, so we are starting the process of highlighting the need for more expertise in general practice.

[248] The other thing to say is that Professor David Greenaway is undertaking a review of the shape of training, so the entire scope of what postgraduate education will look like in the future is up for grabs. The early signs are that there will be a greater emphasis on generalism, so we will train people for longer as generalists, whatever that might mean, and more people in the community, because of the needs of an ageing population. We do not quite have the five-year model yet, but David Greenaway's paper should come out towards the latter half of this year, and that will signal quite a big change in the shape of education, principally because of the need for more generalists.

[249] **Elin Jones:** Can you financially incentivise postgraduate training as part of a recruitment process?

[250] **Professor Gallen:** It depends on what sort of contract you would give these people. Junior doctors' pay is quite good, but their debts are, as of this year, going to be a great deal

more—one would anticipate between £50,000 and £60,000 of debt when they get out of medical school. There have been suggestions in the past about incentivising and writing off the debt or whatever, which have been discussed in Wales. We do not have an answer for that. I still think that if we improve the quality of the training we give them, have our educators better professionalised in their roles and have our trainees on fewer sites with bigger rotas, that experience would far outweigh any financial incentive that we could give them. However, I do not know what a doctor coming out of medical school in five years' time will think about their debt.

[251] **Mark Drakeford:** Three other Members want to ask questions, but Darren has a quick supplementary question on that.

[252] **Darren Millar:** It is a quick follow-up question. You mentioned the Greenaway review and the report that will come towards the latter end of this year. If that requires further changes and another overhaul of the system, and you are saying that you expect to implement an overhauled system in August, which could be about the time of the publication of the report, is your current overhaul not a little premature?

[253] **Professor Gallen:** I would not describe what we are doing as an overhaul. The vast majority—

[254] **Darren Millar:** It is a reconfiguration, is it not?

[255] **Professor Gallen:** Yes. The training reconfiguration is urgent in the specialties that I have outlined—those three we urgently need to do something about, and the time to do that would be in August. With the vast majority of the other specialties, we do have the time to see how the service will reconfigure itself, and we will have the time to see what David Greenaway's review takes forward. The Greenaway review will not be a big bang. It will be about how we do things for the next 10 to 15 years. This is a juggernaut that is very difficult to turn around.

[256] **Professor Donnelly:** I was just going to add to that because I think it is a valid question. One of the core principles around our reconfiguration is sustainable programmes, which does mean an adequate number of participants on a rota, as Jeremy mentioned with regard to providing the 24/7 on-call service. Our best guess is that, irrespective of the shape of training post-Greenaway, there will still be those requirements in terms of consolidation of trainees on sustainable rotas. There is so much face validity to that—you need to see a certain volume on an on-call basis in order to rehearse and practice your skills. Irrespective of what comes out of Greenaway, our take is that there will still be that requirement.

[257] **Vaughan Gething:** I want to pick up and go back a few steps to some of the points that you made earlier about training and its impact. I know that you have been very clear about money not necessarily being the problem, because it is also about getting trainees to the right sites with the right throughput. I am interested that, in your paper and in the oral evidence that you have given, you talk about the fact that you are not currently meeting GMC and royal college standards in a range of different specialities. You also talk about the impact that has on the pass rate, and the consequent effect that then has on your ability to recruit people to training places. I am interested in what that does or does not do to the quality of service then being delivered, because all of these trainees are providing a service during their training. What quality of service are the health boards in Wales therefore able to offer? Should we have any concerns about that in terms of the current service?

[258] You talk in your paper about the difficulty of getting the training right, and how that has an impact on recruitment and retention. You could be a politician—you neatly sidestepped Kirsty's point about the impact on district general hospitals, saying that service

issues were not for you. However, you do talk about recruitment and retention in your paper, and the clear message is that if the training is not in place, then there is an impact on recruitment and retention. We have often been told that recruitment gets more difficult as you go further west, both in south and north Wales, because of access to training of the standard that people want to meet GMC and royal college requirements. Are you basically telling us that that is correct, and that it is more difficult to recruit and retain people in consultant posts as you go further west in Wales because of the difficulties in providing the right level of training?

[259] **Professor Gallen:** To go back slightly with this, we are not training to the quality and the standards that we should in some specialties, hence our need to reconfigure them before the service reconfiguration. We do quality assure training on all of the sites in Wales, and we visit all of the sites in Wales. We have good quality assurance processes that allow us to know very quickly and early if the standard of training that anyone is receiving in whichever specialty is falling short of the standards that we would require. That prompts us to visit and talk to the trainees and education supervisors and then come up with a plan in partnership with health boards that allows us and the trainees to deal with whatever the particular issues are going forward.

[260] We do have increased difficulty in filling rotas and getting people recruited to west Wales and north-west Wales. That is true across most of the specialties. It is still far easier to fill up the M4 corridor than anywhere else, really, in Wales. We have the initiative with the Mersey Deanery to try to help that, so while we have better links there—some of the Mersey medical students are sent here—we are hoping to badge north Wales with a better link to Mersey, starting with paediatrics this August, which means that we will have joint rotations. However, we do intend to increase the number of specialties that we are linking into Mersey as we go forward. I am not sure that I have answered all of your questions there.

[261] **Vaughan Gething:** I just want to be clear about something. We are often told this point about training and that if you do not have adequate training, people will not go to certain parts of the country to fill posts there. My understanding is that you are basically saying that there is real truth to that. I know that you say, ‘Service configuration is not for us; the training is for us’, but am I correct in saying that if you were to pull training and concentrate it on fewer sites, it means that a service cannot be provided as it previously was when training was there, because the staff will not be there, having been moved to different centres? Is that fair?

[262] **Professor Gallen:** We have several examples where we have moved trainees out of units, in full discussion with the chief executive, and the units have thrived from not having the pressure and additional responsibilities of meeting the training standards. So, there are units in Wales where we do not have trainees, and the quality of the service that they provide has, in fact, got better, and that has also allowed us to improve the standards by moving the trainees to somewhere more appropriate.

[263] **Professor Donnelly:** To add to that, we are clearly focusing on trainees as this is in our remit. Clearly, in the health boards, there is a whole range of professionals who can provide a whole range of services. Even though we may reallocate and redistribute trainees to one particular hospital to consolidate them, it does not necessarily mean that the service needs to cease; it will perhaps be a different shape, and, one might argue, a better shape, because the least experienced doctor tends to be the trainee at the front door.

[264] To go back, one of your questions was about the quality of service and the length and quality of training. When we talk about the quality of training, it is a proxy for the quality of service. For example, in the GMC surveys, the trainees will be asked about the level of their clinical and educational supervision. As a clinician, I have to provide supervision to the more

junior staff, whether they are doctors or nurses. So, if we in Wales have trainees who feel that they are not getting adequate supervision, it is clearly a patient safety issue. It is a service issue, but it is interlinked with training; it is a proxy. I therefore think that those two links are important.

[265] **Kirsty Williams:** On that point, I think that we are slightly underselling ourselves this afternoon, because the last time I looked at the GMC survey, where the trainees report in, from what you are saying we would expect red flags everywhere on the survey, when, actually, there are very few red flags reported by trainees in the Welsh NHS. There are a few to do with psychiatry, but actually, we are not out of kilter with the rest of the UK in that regard, are we? That is, if you look at the data.

[266] **Professor Donnelly:** Sure. It was a general point on the link to the quality of training, which is a proxy, in times, for quality of service.

[267] **Kirsty Williams:** I just do not want to frighten people.

[268] **Mark Drakeford:** It is good to get that down.

[269] **Lindsay Whittle:** I note that the purpose of the deanery is to support and commission the education of trainees. As the commissioners, I assume that you are the people who pay. Do you therefore have a say in which countries recruitment drives are undertaken? I know that the immigration rules changed, in 2007 according to your paper, but there are healthy countries like Germany and Canada where, I am told—I do not know if it is true—there are too many health professionals, and they are going abroad. Cuba, I know, exports doctors, but that is perhaps for a different reason. I would be interested in whether you have opinions on where the commissioning of students is undertaken.

[270] Secondly, part of your evidence is that there is this perception that, when people come to Wales, they have to speak Welsh, and they perhaps believe that we have a different currency. I am sure that every foreign student who comes into the United Kingdom will know that there will be a different currency from the country they have come from; does the same apply to Scotland? Is there any evidence of that? I ask because I do not understand that statement, to be honest.

2.15 p.m.

[271] **Professor Gallen:** Starting with the first point, you have to draw a distinction between us commissioning doctors in training and Wales needing fully qualified doctors to provide its service. Recruiting consultants is not what we do, and we also do not get involved with staff grade doctors. We are in a Europe-wide recruitment process for foundation for the first two years following graduation. Individuals from at least eight member states, under General Medical Council rules, are allowed to apply and do apply to come to work here in the UK. There are some restrictions for those who already have full registration, which means that they cannot come in at that particular point, but they can come in after that. We do not have formal links with any country, but it is an open system going forward into foundation. Once they are here, they tend to stay in the UK, so there is that.

[272] I do not know the answer as to how Scotland feels about it. The comments that we put in the paper were reported in the *Western Mail* two years ago, I think, regarding the perceptions that people had when they came to be interviewed here. There were perceptions about the Welsh language and some people thought that we had a different currency and that we did not have a John Lewis store. Other fairly negative things were raised as well.

[273] **Elin Jones:** And these people are graduates of medicine. [*Laughter.*]

[274] **Professor Gallen:** Yes, but not in the UK, obviously. [*Laughter*.]

[275] **Mark Drakeford:** Thank you very much. We have had a really wide-ranging session with a lot of interesting detail in it. For the record, we asked you to come here to explore with us the nexus between service reconfiguration plans and the role of the deanery and so on. In your paper, I thought that you helpfully summarised your overall position, albeit with the different caveats and details that you have explored with us this afternoon. So, I just want to repeat the words that you use in your evidence and ask you to confirm or otherwise whether this remains the deanery's overall position. You state that

[276] 'The Deanery's involvement with the Health Boards and the current plans that we have seen … do suggest that there will be a great benefit to patient care and delivery of care with service reconfiguration. The Deanery believes this will have a positive effect on training, recruitment and retention of doctors who we hope to retain within Wales'.

[277] Is that a fair summary of your overall position?

[278] **Professor Gallen:** Yes, definitely.

[279] **Mark Drakeford:** That is very helpful. Diolch yn fawr iawn. Thanks to all four of you for coming to help us this afternoon. We are not going to have a break—we are not going to leave the room or anything—but there will be a moment or two to allow those in north Wales to beam in on the video link.

Gohiriwyd y cyfarfod rhwng 2.18 p.m. a 2.23 p.m.
The meeting adjourned between 2.18 p.m. and 2.23 p.m.

Cynlluniau i Ad-drefnu Byrddau Iechyd: Tystiolaeth gan y Fforwm Clinigol Cenedlaethol
Health Board Reconfiguration Plans: Evidence from the National Clinical Forum

[280] **Mark Drakeford:** Croeso nôl. Symudwn ymlaen at eitem 10 ar yr agenda, sef tystiolaeth gan y fforwm clinigol cenedlaethol. Croeso i'r Athro Michael Harmer, cadeirydd y fforwm, sydd yma gyda ni yng Nghaerdydd, a chroeso hefyd i Mary Burrows, prif weithredwr arweiniol GIG Cymru. Mary, mae'n neis eich gweld chi a'ch clywed chi lan ym Mangor; diolch am ymuno â ni.

Mark Drakeford: Welcome back. We move on to item 10 on the agenda, which is evidence from the national clinical forum. Welcome to Professor Michael Harmer, the chair of the forum, who is with us here in Cardiff, and welcome also to Mary Burrows, the lead chief executive for NHS Wales. Mary, it is good to see you and to hear you up there in Bangor; thank you for joining us.

[281] Mike, will you lead with a brief introductory statement before I turn to members of the committee who will have questions for either or both of you, I am sure?

[282] **Professor Harmer:** Thank you for inviting me, as chair of the national clinical forum, and Mary, as lead chief executive, to come to give evidence this afternoon. I hope that it will offer us an opportunity to get some clarity around the role of the national clinical forum, particularly areas such as its development, its membership, its relationship with the health boards, its role as perceived perhaps by the members and by others, and to try to correct any misunderstandings that might have occurred in the last year, and perhaps even to correct some misinformation that might be floating around.

[283] The forum has been in place for just over a year, and I was asked to chair it around a month after it started. When it was first set up, it was given an incredibly tight timescale to complete all of the work by summer 2012, which you can imagine was fairly daunting. Due to various reasons, there has been some slippage in that, therefore the forum was asked to be extended for a further year in order to complete its work. During that time—during the process of setting it up and seeing how it works—there have been a few problems; there is no point in beating about the bush. There are some elephants in the room that we have to address. There have been some communication issues and perhaps some matters that we would have hoped to have dealt with better. However, we are there to learn.

[284] So, I hope that today is an opportunity for me to clarify issues for you and to reassure you that the role of the national clinical forum is to support the health boards and not to hinder them. However, it is also a forum through which the experts in healthcare, namely the senior medical staff, nursing staff, therapists and scientists, can give their honest opinions on the safety and sustainability of plans as they are put forward.

[285] **Mark Drakeford:** I failed to reach Rebecca's questions last time around, so I just want to check whether she wants to go first or whether she wants to wait.

[286] **Rebecca Evans:** I will start off. In the introduction to your paper, you say that the role of the NCF is to provide expertise, advice and challenge to the service change plans developed by the health boards. Could you give us some examples of how you have challenged the proposals that you have seen?

[287] **Professor Harmer:** Our process has been to engage with the health boards. We have now met with all of them apart from Aneurin Bevan Local Health Board. We have met with some of them twice. At the first meeting, we discussed their vague impression of what they were planning for the future within their reconfiguration. The second meeting was much more specific, where we discussed issues that they wished to raise with us. So, those meetings were not designed to go through everything with them, but issues that they felt that they needed help with or advice on. So, that is how we have been running things. Examples, which I think have already been raised, relate to the feasibility of maintaining our existing estate in the health service, be those small community hospitals or larger district general hospitals. By using our expertise, we are able to give a view that is not only Wales-wide, but that also takes on board some of the UK issues regarding the availability of staff and so on.

[288] **Rebecca Evans:** On the challenge aspect of your role, you have a set of evaluation criteria by which you examine proposals. I am particularly interested in the criteria on rural-proofing and on whether sufficient consideration has been given to distance and travel time from point of care to the person's home and the implications of that. What sort of criteria do you use to test those?

[289] **Professor Harmer:** When we were first set up, almost at the first meeting, before we even knew what the health boards were planning, we felt that we had to come up with some criteria against which we could judge plans. Certain assumptions were made when we were putting those together. One was that the plan presented to us by a health board would be a total-package plan that would cover the whole of the health service in its area and how it would be reconfigured. For instance, if anyone were to consider changing the configuration of the estate, then travel time would be crucial to ensuring that people were not disadvantaged. So, we felt that we had to stress those particular areas time and again.

[290] We are equally aware that we have a large rural community, which is not only struggling with its healthcare at the moment, but which is likely to see its situation worsen as changes are made in England in hospitals that provide services to Powys across the border in

Shrewsbury and Hereford. They are also changing; therefore, we have to look at how we can rural-proof as best we can. In doing so, we have an expert on our group from the Institute of Rural Health who is able to look at documents and set them against the criteria that it has in a published document to see whether they fulfil those criteria.

2.30 p.m.

[291] **Rebecca Evans:** So, has that individual come up with any conclusions from what he or she has seen so far?

[292] **Professor Harmer:** What we have come up with so far, when we have made submissions or have had discussions, is that we have asked that transport issues are looked at. One issue that has come up time and again is that transport is an all-Wales issue. Many of the things that the health boards need to consider are, perhaps, better considered in an across-the-board look at how we provide transport in Wales: so, the ambulance service, and one of the particular areas that I am concerned about is the emergency air ambulance service and its provision in Wales, which is very patchy at present. So, those are the things that we have looked at and have asked the board to consider in its discussions.

[293] **Mark Drakeford:** As ever, many Members want to ask questions, so I appeal for focused questions. I will go to Darren first, then Kirsty and Vaughan.

[294] **Darren Millar:** Good afternoon, Professor Harmer. Thank you for your paper; it is very helpful. Earlier, you alluded to the elephant in the room, so let us try to get the elephant dart out and deal with it. You will be aware that concerns were raised last year about how you had communicated with Betsi Cadwaladr University Local Health Board in terms of the national clinical forum's official response to the board's reconfiguration proposals. Can you tell us why you made such significant amendments to the document? Those are all in red in front of me, and, as you know—you amended it—a large part of the document is in red. Why did you make such significant amendments and why, in particular, was the conclusion about the opinion of the NCF changed in such a dramatic fashion, from expressing significant concerns to expressing outright support?

[295] **Professor Harmer:** Yes, of course I can. On the surface, it seems totally bizarre that that happened.

[296] **Darren Millar:** It certainly does, yes.

[297] **Professor Harmer:** It is probably best to take you all through the process as we undertook it. Before we received any of the consultation documents, we had produced our criteria for evaluation. At the last meeting of the clinical forum before the submission of the response, which was on 16 November, we were not aware at that stage that Betsi Cadwaladr LHB had decided not to include secondary care in the consultation—in other words, deliberately decided that. I gather that you were made aware of it on 20 November, when you met Geoff Lang of Betsi Cadwaladr LHB. We were not aware of that; therefore, we had to put in a submission that was, clearly, heavily critical of not including it. That was the original one that went in, so when the response said that there were significant areas that required reconsideration, that referred purely to that major area of the district general hospitals and the services provided in them.

[298] That response was submitted, and I received a short reply from the chief executive saying that we had, perhaps, missed the point of the consultation. I therefore contacted them on the Monday, and it was then that I became aware that it was a deliberate ploy, a deliberate decision of the board of Betsi Cadwaldr LHB, not to include those things. I then spoke to several members of the forum and we all felt that we should redraft or resubmit the response,

looking at the document that the board had submitted but now with the assurance that the concerns that we had raised over those hospitals would be addressed in a secondary process. You will notice that, although there is a lot of red in the document, those are additions. We went through the document page by page to provide the comments made by the forum.

[299] **Darren Millar:** It is obviously important that we get reconfiguration right for the people of Wales. We need to ensure that there is a transparent process, yet you deliberately chose to communicate on this particular issue with the chief executive of the health board through private e-mails. Does that not send completely the wrong message to members of the public about the way in which you, as chair of the national clinical forum, are behaving?

[300] **Professor Harmer:** Again, I can see why you would believe that. It was late in the evening when I finished redrafting that document. I wrote the original one. It was not that I took someone else's document and rewrote it; I rewrote it myself because I had written the first one. It was late, and I decided that, in order for me to get a reply out of hours from the chief executive, I would send it to a private e-mail address. When read that way, it sounds very sinister, but it was not meant to be. It was purely that I needed to know, by that Thursday morning, that I had addressed the concern that the LHB had that we had completely missed the point about what was in its document. That is why I did it. An awful lot of documents that I deal with, I deal with through private e-mails in the evening.

[301] **Darren Millar:** I find it astonishing to believe that you would think it appropriate to behave in that way. Certainly, to refer to it implies that you are trying to hide something in your e-mail. However, we will park that there. You have given an explanation, which I will have to accept. I would like to ask about the issue of secondary care. The public consultation document that was published by the Betsi Cadwaladr University Local Health Board did not mention secondary care. You were supposed to report back on that specific document and its contents. I find it very difficult to understand why you were not able to fathom that that was not part of what the health board was proposing. Why were you so far adrift in not understanding that those were the consultation proposals and that was what you needed to respond to? Why were you commenting on something that was completely outside of the proposals that were on the table?

[302] **Professor Harmer:** It is very difficult, because part of the process that we had with the health board was to discuss those issues with it. Therefore, I suppose that a large part of the response letter that went back in July was a discussion of those issues. The feeling was that that had been ignored and, if it had been ignored, that was of major concern to us. At that stage, there was no indication made to me personally, or to any members of the forum, that there would be a secondary process that would deal with that.

[303] **Darren Millar:** So, what is your understanding now of this secondary process or this 'deliberate ploy'—I think that those were the words that you used earlier on?

[304] **Professor Harmer:** I think that 'ploy' is the wrong word. A decision was made that more work was needed because we had identified areas that we felt needed more work—to look at interdependencies and the feasibility of different configurations within the health service in north Wales—and that that would take longer than the timescale within which the consultation should come out. Therefore, that was what happened. As I say, I do not want to go into the rights and wrongs of where there was a lack of communication, because I do not think that that is helpful. Somewhere along the line, however, we failed to appreciate that.

[305] **Darren Millar:** I have one final question. It seems to me that you are expecting a further piece of work or consultation on those secondary care issues, but you can confirm that in a few moments. However, in terms of the significant amendments that were made to the original submission, which was subsequently withdrawn, can you confirm what the process

was for securing the agreement of the other members of the clinical forum prior to this being sent? In relation to the covering e-mail that you sent with the document to members of the forum, all of whom have other day jobs within the Welsh NHS, you sent it at 10.09 a.m. and you were expecting them to be able to respond just after lunchtime, in order for it to be circulated and sent up to north Wales. Was that not completely unreasonable, given the massive change to the overall recommendation in the report?

[306] **Professor Harmer:** It was a short timescale, but a whole stream of e-mails had been sent a week before that, discussing what needed to be changed. Wherever that document came from—and I know that it came from a member of the forum, because of the format in which it was sent—and whoever made it available to you, they did not make available the remainder of the e-mails that clearly highlighted the areas that we were going to change and the parts that we needed to alter. So, I fear that you may not have had all of the information that was available to that person.

[307] **Darren Millar:** You will appreciate that it is difficult for any of us to have all of the information. I have one final question. It is an important question. The terms of reference for the national clinical forum refer to the fact that there should be two co-chairs. I understand that you are the only chair of the forum. Why are the terms of reference not being met in that respect?

[308] **Professor Harmer:** As I say, I was asked to co-chair. I do not know whether it might be more appropriate for Mary to take that question, but my view of it was that the timescale that we had was incredibly tight when we started. By the second meeting that we had, we were unable to identify an appropriate co-chairman from another country. We had looked at Scotland and England and were unable to find an appropriate person to come to do it. The forum, as a body, then felt that it was not unreasonable that we continue with a single chair.

[309] **Mark Drakeford:** Thank you. Mary, we are very pressed for time, but, given that the last conversation referred to your part in some of the events, is there anything that you briefly wish to add to what we have heard from Professor Harmer so far?

[310] **Ms Burrows:** I think that it is important to realise that I am here to represent the NHS chief executives, but I anticipated that this would come up—so, as long as we can be clear that there is no conflict of interest in what I am answering.

[311] I would support what Professor Harmer said; there was nothing sinister in what we were doing. Sometimes it was the way of working. As for whether we could have got the communication better, I think that we have both acknowledged that that is the case. Looking back at our consultation document, I could see where a conclusion could be drawn that we were not consulting on that particular issue, and that was the tenor of our conversation.

[312] In terms of the co-chair, Professor Harmer is completely right: we did seek to support him in the role but were unable to do that. Given the work that it needed to do, the forum felt that he was perfectly capable, with the quality of individuals that he had around the table, to carry on that role.

[313] **Mark Drakeford:** Thank you. Kirsty is next and then Elin.

[314] **Kirsty Williams:** Professor, to whom are you accountable in your role as chair of this organisation?

[315] **Professor Harmer:** I would report back to the lead chief executive of the local health board, namely Mary.

[316] **Kirsty Williams:** Could you explain the relationship between the forum and the Welsh Government?

[317] **Professor Harmer:** There is no relationship. There are observers on the forum. The chief nursing officer and the medical director, as he was then, of NHS Wales are observers on the forum. As chair, my philosophy is that, while I value observers, I also use them if they can provide information that is not available elsewhere. So, I would involve them in discussions if we needed to know whether there were impending policy changes that would impact upon this. Apart from that, those are the only links that I have had with the Welsh Government.

[318] **Kirsty Williams:** Do you not think that it is a curious situation that you are accountable to an individual, or a group of individuals, on whom you are passing judgment? After all, you have just said that you are accountable to the lead chief executive of the health board, and yet you are expected to be able to criticise and to challenge the very work that those same individuals are passing to you. Does that not make you sometimes feel uncomfortable that you have been placed in a situation where you are sometimes being asked to be very tough and harsh on the very people to whom you are then accountable in your role?

[319] **Professor Harmer:** I can see your point, and sometimes it could feel that way. However, equally, in my other role within the health service of chairing Welsh Health Specialised Services Committee, I have to try to co-ordinate all of the health boards into a united view on how we deal with specialist services. So, I am quite familiar with working with a whole group and reporting to it as its chair, because I am actually the chair of its sub-committee. So, as such, I do not have a big problem with it. In fact, I think that it probably says a lot about the trust that we have in each other that I appreciate that I have to report back to the chief executives because it was the local health boards that set up the national clinical forum. It does not cause day-to-day conflict. You say that we produce criticism; I do not necessarily think that it is always criticism. I would like to think that, most of the time, it is constructive for them to actually guide some of the decisions that they want to make.

[320] **Kirsty Williams:** Given the very controversial nature of the reconfiguration of any hospital services—even the smallest reconfiguration can cause a huge amount of public angst, and we are not talking about small things here; we are talking about potentially very large changes—do you not think that it would have been better to have avoided the potential view from the outside of this relationship between you and individual health boards?

2.45 p.m.

[321] Will you be asked to submit your views, whether in draft 1, 2, 3 or 4, to the Minister for health? My understanding of the establishment of the national clinical forum is that it was there to give independent clarification and say-so, and this was hailed by the Minister as being the way in which ordinary members of the public could have confidence and certainty that health boards and politicians were out of this process and that what would come out of it would be clinically sound. That is how it was sold to all of us and to the public.

[322] **Professor Harmer:** When I came in as the co-chair, subsequently the chair, I would suggest that that was my understanding as well, but as I was not privy to its establishment, it is probably more appropriate to ask Mary, who I think was involved in that establishment process, how it came about. I was not; I took it over in an established form.

[323] **Mark Drakeford:** Mary, Kirsty described the way in which the forum and its purpose were originally advertised by the Minister. Did you recognise her description?

[324] **Ms Burrows:** I will not answer for the Minister, and I think that you would not expect me to do that. I can give you the chronology of how we set it up, which was a

conversation with Dr Chris Jones who, at that point, was the medical director for the NHS, and we talked about reconfiguration and the importance that we placed in the NHS on an impartial view. If you look across the border in England, you will see that they have had an independent configuration review panel for many years. Some of us who had worked in that system felt that we should have something similar, but more tailored to our needs, and that it was something that we should do. We wanted to make sure that it had some impartiality and, therefore, we felt that the NHS should take responsibility for that, recognising that there might be some misperceptions or tensions in how that might look. However, we took that on in order to help advise us. That is the genesis of how the clinical forum was set up. I was involved in that, as well as the other chief executives at the time. Professor Harmer's role followed an appointment process, because of the legislation for the specialised services committee. He was the obvious candidate because we had faith in him. He can challenge us quite harshly sometimes, which is absolutely right. You need that reflection. We then went forward with the terms of reference and agreed them as a clinical community and one of the NHS leaders. That is the genesis of that, if that helps.

[325] **Kirsty Williams:** Thank you very much, Mary; that is helpful. To clarify, whose idea was it to create the national clinical forum and who commissioned that forum?

[326] **Ms Burrows:** It was combination of us, in the conversations that we would have with the medical director of the NHS, chief executives and some of our clinical colleagues. I cannot say that one person said, 'Here's my bright idea, and this is what we'll do'. It was about looking at how we made sure that we got some impartial advice. So, it was a combination of many of us and, in fact, I do not think that I was there when a number of chief executives talked it through at a second stage in order to come up with the idea. We then took it forward and agreed it as a group of chief executives, with the support of our chairmen. So, I do not think that it was just one person, if that helps, Kirsty.

[327] **Kirsty Williams:** That is most clear, thank you very much.

[328] **Mark Drakeford:** I will go to Elin next and then to Vaughan.

[329] **Elin Jones:** I read the national clinical forum's response to the Hywel Dda consultation at lunch time and, as the Assembly Member for Ceredigion, I should thank you for recognising in your work the strategic importance and special circumstances of Bronglais General Hospital. In that response, you have done part of the job that I always foresaw that the national clinical forum should be doing, that is, rather than allowing local health boards to look just within their borders, to get them to think about the role of those services for the people beyond their borders whom they served as well. Thank you for that.

[330] We are in a slightly difficult position. The timing may suit you, but possibly does not suit us in that, next week, we will know finally what the plans are for Betsi Cadwaladr and Hywel Dda. If we look at your views to date on the plans for consultation, then clearly in the case of Hywel Dda, there is a divergence between your view, preferring and advocating a two-site model for the longer term sustainability of the health service in that area, and Hywel Dda's view that there should be a three-site model of secondary care. If Hywel Dda persists with its view on a three-site model—and the same may well be true of the Betsi Cadwaladr area—what do you see as your role after the plans for those two health boards are announced next week? Clearly, you have come to a very informed view yourselves as to what is sustainable in the longer term. Would you advise the Minister that the health boards have not come up with a model that is in the best interests of the Welsh NHS?

[331] **Professor Harmer:** It is very clear that our role in the process was to provide advice that is, hopefully, independent and impartial. Our submission is to be dealt with along with all the other submissions of interested parties. If it is the decision of the health board that the

response that we have put in does not convince it, then that is its decision. There would be no route through which I would then go to the Minister. There would not be a route for me to take. That is not part of the terms of reference of this group. If the Minister feels that further consideration is to be given, she might wish to ask for that. However, I do not see it as black and white. What is likely to happen is that the forum will be asked to work with the health boards to try to find the best way forward. I do not think that it will be one proposal or the other—there will be a middle ground that we will need to steer towards. I have said all along that the forum would be more than happy to work with those health boards on any further work that they wanted, but there is no route through which I could or would transfer our report anywhere but to the health board.

[332] **Elin Jones:** So, if a situation occurs where a decision on a particular service is referred to the Minister for a final decision because there is a disagreement between the community health council and the local health board on the service in an area, you do not see the national clinical forum providing any advice at that point to the Minister.

[333] **Professor Harmer:** I would not expect that because the appropriate route would be that she would go through the chief medical officer, who would then seek advice as appropriate.

[334] **Kirsty Williams:** You have very senior Welsh Government officials in attendance at your meetings, and these are busy people—they are not people who do not have a lot to do. Why are they there, in your view?

[335] **Professor Harmer:** As I said, I value their presence inasmuch as, while they are there to observe, they can also flag things up and ask questions if there is anything in policy that is likely to impact upon plans for the future. I know from working within the Welsh Government myself that policy is developing all the time, and therefore it is useful to have them there. Equally, I recently received a letter from the chief nursing officer saying that, because of her commitments, she can no longer make it to the forum, and she feels that she will have adequate feedback from the other members representing nursing and midwifery.

[336] **Vaughan Gething:** I wanted to pick up one of the points in your paper. It is partly this point about trying to ensure that NHS reconfiguration is not seen to be led simply by money, or by what are often referred to as bureaucrats or administrators—it is this point about there being a clinical need for reconfiguration that is supported by a clinical consensus. In your paper, though, there is a paragraph that talks about the relationship with the local healthcare professionals fora, saying that you expect them to be consulted, and that you would consult with them as you deemed appropriate. You say that you might delay a review of the service change plans until you had had an assurance that the local fora had been consulted. I just wanted to ask specifically, taking the two examples of Betsi Cadwaladr and Hywel Dda, what relationship you have had with those local healthcare professionals fora, what those fora look like and how those relationships have been managed. What level of assurance have you received that there is clinical consensus in both those health board areas on the sorts of reconfiguration plans that are being proposed, and whether there is a clinical justification for the service change?

[337] **Professor Harmer:** Of the two that we have dealt with, we have had slightly different relationships with the local clinical fora. We certainly had a much closer discussion with Hywel Dda and have been reassured that the local medical forum is on board. Having said that, there will always be people in that group who will strongly disagree with it; equally, there will be people who are not in the local forum, let us say, who are quite vocal about their concerns.

[338] We have not had as close a relationship with Betsi, and that may be geographical as

much as anything. We had two visits up there, and I have been given assurances that, in general, the local clinical forum is supportive. I am equally aware, however, that a number of current clinicians are vocally opposed to some of the changes.

[339] In hindsight, given more time, I think that that is an area on which we would have wanted to spend more time, but, as I said, when we started this, we were given literally six months to complete the work. The amount of time allocated to me for this job is a princely two days a month, and all the other members of the forum are full-time clinicians or similar. It has therefore been quite difficult to ensure that we have done all of those. We have touched upon it, and I would want a better relationship with the fora for the other health boards that we deal with.

[340] **Vaughan Gething:** Can I just pick up on two points? First, on the clinicians outside the consensus view that you are presented with, how do you deal with their views? For example, do they contact you directly and say, 'We think the view that you're getting is wrong, and here's why'? If they do that, how do you take account of that, or do you just say that they are not part of the local clinical professional fora, so you will not think about what they are saying?

[341] There is also the point you raise about Betsi Cadwaladr and the difference in the relationship and whether that has an impact on the conflicts that you have in the proposals. Also, given that you say that you have had assurances that the consensus is there, where has that assurance come from? Has it come from the forum, or has it come from the health board? The danger is that if the assurance comes from the health board, the obvious opponents to any reconfiguration would say, 'Well they would say that, wouldn't they?' I am interested in that level of relationship.

[342] **Professor Harmer:** Taking the first point, to date, nobody has contacted me directly, as an individual. I have been contacted directly by the Royal College of Surgeons of England, which wished to put its views on some of the reconfiguration plans. However, it also submits its own response, and I felt that its response was appropriate; it is for the college to decide what it wants to put in there. In the forum there is a representative of the surgeons who would also put their points forward. So, nobody has actually contacted me. Were they to do so, the approach would be that I would share that information or that concern with the members of the forum and ask them how they wished to deal with it. We would certainly take it on board, because I am equally aware that you can sometimes get a situation in a health board of an inner clinical clique of clinicians who are happy to go along with everything when the majority of their colleagues are not. I have not seen strong evidence of that, but if people were to contact me, I would have to take on board what they said and deal with it in the forum.

[343] Sorry, but the second point has completely slipped my mind.

[344] **Vaughan Gething:** You talked about not having the same level of contact with Betsi, but that you had received assurances that the view presented to you did represent a consensus. How was that arrived at?

[345] **Professor Harmer:** The main assurance came to me from the medical director, whom I have known for many years. So, it was through that. Equally, within the forum, we have people who work within all the health boards, and I sought assurances from those working in Betsi and Hywel Dda that appropriate local measures had been taken to consult clinicians. They provided that to me.

[346] **Darren Millar:** May I just ask a follow-up question there? Why would the relationship with Betsi be so far removed, given that the chief executive that you are accountable to is the chief executive of Betsi, Mary Burrows? Why is there a disconnect?

Why is that an issue? You are shaking your head, Mary.

3.00 p.m.

[347] **Professor Harmer:** It is not. Probably, it is more the fact that I have had longer to spend with the Hywel Dda group and the clinicians. That is partly because of geographic reasons. The majority of the forum's members are based in south Wales, so we have had longer meetings when we have met with them—they have been all-day meetings. Meetings up in north Wales are an issue that we have to fit into the day. It may just be that I have a feeling that we have not spent long enough time with them. Within the time constraints that we were given when we were set up, that was almost inevitable.

[348] **Ms Burrows:** The healthcare professionals forum has submitted its response, because it was set up under legislation. We have given due regard to the forum, so it has been engaged. Professor Harmer makes the point that we have not had as much time because of the geographical issues, despite the fact that all of them have come to Wrexham on two occasions. I hope, Darren, you are not implying that simply because I happen to be the lead chief executive—I will be in post until the end of March and there will then be another chief executive that Professor Harmer will liaise with—that I would expect him to treat me any differently than anyone else. Perhaps you are not implying that there is a special relationship between us.

[349] **Darren Millar:** No. May I check one other thing? You mentioned the time constraint that the clinical forum was up against. Do you think that it is wise to simply set another 12 months in advance as being the end time for the clinical forum, particularly given that there may be a requirement for further consultations in the future because of the current consultation guidance, which is problematic in some respects? What do you think needs to happen to the forum? Do you think that it just needs to be under constant review as to when its end time comes, or do you think that the consultation guidance might need to be changed?

[350] **Professor Harmer:** The forum has been extended for another year, to be reviewed at that stage. I believe that there will come a time fairly soon when we will look at whether the forum is necessary within that role any longer. Many of the issues that we have raised are not so much on the actual reconfiguration but on the implementation of those changes. Many of the cautious areas where we have raised concerns are implementation issues. It may be that the forum will have a national role in implementation rather than just looking at the plan, particularly with regard to aspects such as moving care into the community and the impact on general practice. That is an implementation issue. I think that we all agree that it is the right thing to do; it is about how you do it.

[351] **Darren Millar:** On that point about consultation, does the forum have a view about the adequacy of the consultation guidance that health boards have to work with?

[352] **Professor Harmer:** I think that the forum is reasonably comfortable with it as it is. We have only seen two consultation documents, and I think that everyone realises that they are totally different in their structure. One is the let-us-try-to-do-it-all-in-one-go approach, and the other one is let-us-look-at-some-areas-and-leave-the-others-alone approach. At the moment, we are wondering what will happen with south Wales, because that is being dealt with in different sections. Certain specialist areas are being dealt with by the south Wales programmes and others are being dealt with by the individual health boards. We are still in a situation of some flexibility.

[353] **Mark Drakeford:** Mary, as we have heard today, the forum is commissioned by the chief executives group. Are there any views among the chief executives on the point that Darren is making about whether the forum ought to be a more permanent part of the

landscape, rather than being on a year-on-year renewable basis?

[354] **Ms Burrows:** If I am honest, I do not think that we have come to that decision yet. We found very quickly how helpful the forum was in terms of its impartiality, and we therefore took the decision that we really needed to have it with us. So, I think that we need to work this through; we need to see how the south Wales programme goes. Reconfiguration and service change is an evolving issue—it is not done in one go and that is it, because a lot of issues will emerge in terms of advancements and technology. My personal view is that the forum has some value, but we would need to see how it would evolve over a period of time. However, it is something that we would want to discuss as a group, and Professor Harmer will have the view of whether it adds value, and that is the important bit that we need to ensure that we keep an eye on. Currently, we are very happy with it; we took the decision very quickly that we value the forum and that we need to keep it with us.

[355] **Mark Drakeford:** Thank you very much indeed; it has been a very interesting session and you have very helpfully cast some light on the way the forum has been working and the job that it has been asked to do. This will be very helpful for committee members.

[356] Diolch yn fawr iawn i chi'ch dau am ein helpu y prynhawn yma.

I thank you both very much for helping us this afternoon.

[357] **Professor Harmer:** Thank you very much.

[358] **Mark Drakeford:** Dyna ddiwedd ein sesiwn agored am heddiw. Mae un pwynt arall ar yr agenda, ond rydym yn mynd i sesiwn breifat yn awr.

Mark Drakeford: That concludes our public session for today. There is one further item on the agenda, but we will now move into private session.

3.05 p.m.

Cynnig dan Reol Sefydlog Rhif 17.42(vi) i Benderfynu Atal y Cyhoedd o'r Cyfarfod
Motion under Standing Order No. 17.42(vi) to Resolve to Exclude the Public from the Meeting

[359] **Mark Drakeford:** Cynigiaf fod

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

Mark Drakeford: I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(vi).

[360] Gwelaf fod Aelodau'n fodlon.

I see that Members are content.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 3.05 p.m.
The public part of the meeting ended at 3.05 p.m.