Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Iau, 19 Mawrth 2014
Thursday, 19 March 2014

Cynnwys
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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

Peter Black	Democratiaid Rhyddfrydol Cymru (yn dirprwyo ar ran Kirsty Williams ar gyfer eitemau 1 a 2) Welsh Liberal Democrats (substitute for Kirsty Williams for items 1 and 2)
Alun Davies	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
Jenny Rathbone	Llafur (yn dirprwyo ar ran John Griffiths) Labour (substitute for John Griffiths)
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Stephen Coole	Undeb Cenedlaethol Myfyrwyr Cymru National Union of Students Wales
Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour, (Minister for Health and Social Services)
Vaughan Gething	Aelod Cynulliad, Llafur (y Dirprwy Weinidog Iechyd) Assembly Member, Labour, (Deputy Minister for Health)

Dr Andrew Goodall	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director General, Health and Social Services, Welsh Government
Sue Goodman	Y Wallich The Wallich
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio, Llywodraeth Cymru Director of Social Services and Integration, Welsh Government
Lucy-Ann Henry	Undeb Cenedlaethol y Myfyrwyr National Union of Students
Dr Ruth Hussey	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Yr Arolygydd/ Inspector Nick McLain	Heddlu Gwent Gwent Police
Michele Millard	Spire Cardiff Hospital ac yn cynrychioli Cymdeithas Gofal Iechyd Annibynnol Cymru Spire Cardiff Hospital and representing Welsh Independent Healthcare Association
Melanie Minty	Fforwm Gofal Cymru Care Forum Wales
Paul Roberts	Arolygiaeth Carchardai Ei Mawrhydi Her Majesty's Inspectorate of Prisons
Simon Rogers	Iechyd Nuffield, Ysbytai Caerdydd a'r Fro ac yn cynrychioli Cymdeithas Gofal Iechyd Annibynnol Cymru Nuffield Health Cardiff and Vale Hospitals and representing Welsh Independent Healthcare Association
Lisa Salkeld	Gwasanaethau Cyfreithiol, Cynulliad Cenedlaethol Cymru Legal Services, National Assembly for Wales
Martin Sollis	Cyfarwyddwr Cyllid yr Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director of Finance Department of Health and Social Services, Welsh Government
Prif Gwnstabl Cynorthwyol/ Assistant Chief Constable Jon Stratford	Cymdeithas Prif Swyddogion yr Heddlu Association of Chief Police Officers
Anne Thomas	Linc Cymru ac yn cynrychioli Fforwm Gofal Cymru Linc Cymru and representing Care Forum Wales
Philippa Watkins	Gwasanaeth Ymchwil, Cynulliad Cenedlaethol Cymru Research Service, National Assembly for Wales
Antonia Watson	Y Wallich The Wallich
Kirsty Williams	Aelod Cynulliad, Democratiaid Rhyddfrydol (Aelod sy'n Gyfrifol am y Bil) Assembly Member, Liberal Democrats (Member in Charge of the Bill)

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

Helen Finlayson	Ail Glerc Second Clerk
Siân Giddins	Dirprwy Glerc Deputy Clerk

Gwyn Griffiths	Cynghorydd Cyfreithiol Legal Adviser
Llinos Madeley	Clerc Clerk
Siân Thomas	Ymchwilydd Researcher

Dechreuodd y cyfarfod am 09:01.
The meeting began at 09:01.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome members of the public and committee members to this morning's session of the Health and Social Care Committee? This morning we'll be having our final evidence sessions on the Safe Nurse Staffing Levels (Wales) Bill. Can I, first of all, remind everyone to turn their mobile phones off or put them on silent, and switch any equipment off that may interfere with the broadcasting equipment? There is no scheduled fire alarm, so if one does occur, please follow the directions of the ushers to the assembly point by the Pierhead. Can I welcome Peter Black, who is substituting on behalf of Kirsty Williams in this session? We've received apologies from John Griffiths, and I welcome Jenny Rathbone, who will be substituting for John this morning. The meeting is bilingual, so if you do need to use the translation services, it's channel 1 for Welsh to English simultaneous translation, and channel 2 if you need amplification. We'll move on to the next item on the agenda.

09:03

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 14
Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 14

[2] **David Rees:** Can I welcome the Member in charge, Kirsty Williams, to this morning's session? Can I ask you to introduce your team, please, Kirsty?

[3] **Kirsty Williams:** Thank you, David. I'm joined this morning by Philippa Watkins, who has been providing research assistance to the Bill, and Lisa Salkeld, who is providing legal advice.

[4] **David Rees:** Okay; thank you. Can I welcome you both? Thank you very much, also, for the additional evidence you've provided to the committee during its progress. I understand you don't wish to make an opening statement.

[5] **Kirsty Williams:** No, Chair, I'm quite happy to go to questions from Members.

[6] **David Rees:** Then we'll go straight to the questions and start with Gwyn Price.

[7] **Gwyn R. Price:** Thank you, Chair. Good morning, everybody. Could you tell us why legislation is needed, given the Minister can already use powers of direction to require local health boards to comply with the nursing acuity and dependency tool, which includes ratios?

[8] **Kirsty Williams:** Thank you, Gwyn, for your question. I think I start from the premise that the Minister has had these powers since 2006, to issue directions, and has not done so, even in the face of widespread concern about nurse staffing levels—safe staffing—and the impact on patient care. So, I'm concerned that, whilst those powers have been

available for some considerable time, the Minister has chosen, for whatever reason, not to issue those directions. I'm also aware, from reading the evidence, that the Minister has indicated that, perhaps, he would be willing to do so, later on this year, and I'm grateful that, if nothing else comes out of this process, Chair, and we don't end up with legislation, perhaps this debate will have at least pushed the Minister to do that and all of this work will not have been for nothing. I don't think that the Minister is trying to mislead us in any way, but, with all due respect, the Minister could fall under a bus tomorrow and we could have a—I hope he doesn't—

[9] **David Rees:** We all hope he doesn't.

[10] **Kirsty Williams:** Yes. We could have a new Minister with different priorities, with a different focus, who is not willing to make those directions and we could then all stand up in the Assembly Chamber and call upon the Minister to do so and he or she could consistently rebut that. So, I think we need legislation because it actually surpasses an individual Minister and it creates a scenario where this legislature can have a greater say and use the opportunity to make it happen rather than rely on somebody else to do it for us. The nature of what the Minister would be able to do is also limited. My understanding is that the powers that he has to make directions would be with regard to the mandatory use of the acuity tool. This legislation goes beyond that. Yes, it does talk about using the acuity tool, but it also mandates the ability of professional judgment as well as ratios. My indication, from what I've seen from the Minister, is that he is only referring to making directions with regard to the acuity tool, so I think that this legislation goes further.

[11] I don't know whether you look at the directions. If you look—if you can find them on the Welsh Government's website—you'll see that the Minister has made a number of directions to local health boards over the last 12 months, directions that this committee has had no scrutiny over. I suspect that Members around this table—. I certainly didn't know half of what the Minister has issued directions on over 2014. We've had no say on that, we've had no scrutiny of that, and, if we don't know that, then the public certainly don't know it. What's important about this legislation is that it strengthens the arm of front-line staff and members of the public to say, 'I know that there is a law in this land that says that this local health board has to provide that safe staffing level'. So, I think that this process gives us a permanency, a certainty, it gives power to the legislature and it gives power to ordinary members of the public to be able to hold local health boards to account, and it ensures it happens, not just now but actually in perpetuity until another Minister is willing to come back and rescind this legislation.

[12] Gwyn, I've always sat when I've looked at legislation and thought to myself, 'We have to legislate not just on the basis of what this Minister says'. Actually, next year, we could have a different Government. Darren Millar could be the health Minister, Elin Jones could be the health Minister—

[13] **Gwyn R. Price:** Well, I don't think you want to go that far.

[14] **Kirsty Williams:** Maybe Darren Millar's priority is not nurse numbers. Maybe Elin Jones's priority—Plaid Cymru's priority—is doctors and recruiting a lot of doctors. Therefore, this is the opportunity that gives permanency to establishing the principle of safe staffing regardless of who is in charge and who the Minister is, something that the power of direction from the Minister cannot achieve.

[15] **Gwyn R. Price:** So, all in all, this can only help the Minister, in your opinion.

[16] **Kirsty Williams:** It can make sure it happens in a way that relying on the Minister's commitment to powers of direction can't.

[17] **Gwyn R. Price:** Thank you, Chair.

[18] **David Rees:** I've got three people now indicating to follow up on this. I'll start with Elin, then Jenny and then Janet.

[19] **Elin Jones:** The Minister sent a clarification note to us last night, I think. I'm not sure whether Kirsty Williams has seen that note, where his defence of why he hasn't used his powers to direct at this point is that the acuity tool hasn't completed its development and validation, but it is expected to do so by summer 2015. He doesn't confirm in this note that he would use those powers. Do you want to explain to us what parts of the Bill, then, add to the acuity tool? You made reference to professional judgment, but, if the powers exist to mandate the acuity tool, then surely the powers equally exist for him to expand on that and to direct health boards to take into account the various other aspects around professional judgment and nurse-sensitive indicators, that is apparently called the triangulated approach.

[20] **Kirsty Williams:** It's a horrible word, isn't it? The Minister's direction-making powers cannot be used to impose an enforceable statutory obligation of an overarching kind on NHS bodies in Wales to build the need for safe staffing and nursing levels into their key strategies and policies, including budget setting. This Bill creates an overarching obligation, and the powers of direction, I do not believe, and I've been advised, cannot make that happen. You'll be aware, from what the Minister has said, that he's only talked about using those powers of direction with regard to the acuity tool, and you will be aware that, within the legislation, we do try and create this triangulated approach that looks at ratios, the acuity tool, and the professional judgment of the staff in charge. I see no indication, from what the Minister has said, of his willingness to use his powers of direction to do those things.

[21] **Elin Jones:** In his evidence, if I understood it correctly from the Minister, he did say that, if this Bill was to proceed, he would certainly want to see some of the aspects of detail on the guidance to be issued reduced, because it was too—. Was it too specific or too—? It needed—. It was too specific; I think he wanted quite a bit of it to be taken out of there. So, he's obviously focusing in on the acuity tool. What is lost, then, if that is taken out, either of this Bill or if we end up just with a mandated acuity tool?

[22] **Kirsty Williams:** The acuity tool is just one element of deciding what I would regard as a safe establishment on the ward. Therefore, if we are completely reliant on the acuity tool, I think it's a step forward from where we are now, but it does not create the overarching statutory obligation so that when chief executive officers, financial officers, medical directors and chief nursing officers are sitting there looking at their strategy for the three-year plan, which they're required to submit to the Government, then they're not looking at that because the acuity tool is only used on a ward-by-ward basis on a day-by-day basis. It's not the overarching strategic aim that this Bill will seek to achieve. Then, we do drill down to what is—it's a horrible word—the triangulated approach. The acuity is just one element, I believe, in delivering safe staffing. You cannot deliver safe staffing by using acuity tools alone. You have to be in a position of looking at the professional judgment of the staff in charge as well as issues around ratios, and I see no indication from the Minister of his willingness to issue directions in those ways. I come back to the point that directions cannot be used to create that overarching statutory requirement on the local health boards. He can't do that. Let alone, then, the issues around scrutiny, compliance, measuring and the permanency that that letter—because that's what it comes in, it comes in the form of a letter—. It would not necessarily come before this committee. It wouldn't necessarily come before the Chamber. I know, from listening to other evidence sessions, and from listening to Members, they're concerned about, you know, how do we judge compliance, and how do we judge whether this is working. That system of offering directions via a letter would mean that there was none of that available to us except for, perhaps, questions to the Minister or scrutiny sessions here, which I think is one

of the strengths of the Bill: that we have tried to create a framework by which we could judge the effectiveness of the legislation. So, acuity does look on a day-by-day, ward-by-ward basis, but it's a workforce planning tool; it's not a safe staffing tool.

[23] **David Rees:** Jenny.

[24] **Jenny Rathbone:** I've got two reservations. One is: if you mandated or legislated to have these ratios in hospitals, what would be the impact on primary care? Wouldn't it suck out nurses from primary care, or indeed from the third sector care sector?

[25] **Kirsty Williams:** The first thing to recognise, Jenny, is the overarching duty, which applies to all services that are commissioned and provided for by a local health board, and that's the overarching aim of the Bill. So, they would be in breach of that if they were denuding and ignoring safe staffing levels in any of the services they were responsible for commissioning or delivering.

09:15

[26] **Jenny Rathbone:** Sorry, we know that when you put the spotlight on one thing, it means people take the ball off on another thing, so, if you don't have mandatory nursing levels in primary care, it is inevitable that there would be a real challenge in getting nurses into primary care.

[27] **Kirsty Williams:** What the Bill is trying to do in the first instance is to create the statutory underpinning of safe staffing across all services in Wales. It then goes on to focus on a particular sector within the health service. It has done so because that is where—not in Wales, predominantly—we know that there is an issue around safe staffing. We've seen it in the—

[28] **David Rees:** We're aware of the purpose of the Bill. I think the question is: is this one of the unintended consequences?

[29] **Kirsty Williams:** I've not seen from the international examples that that is a case. I think there is concern—and I would accept that there is concern—about being able to provide the nurses and getting the nurses back into the service, but what we do know is that, actually, where this has happened before, it brings nurses back into nursing; it makes nursing a more attractive profession, because people will know that they're working in an environment alongside the appropriate number of colleagues that allows them to do it. It brings people in off bank and agency back into permanent positions. And, actually, we do need to increase the number of nurses, but we're responding, in the first instance, to a very specific set of concerns and circumstances. That's what we're trying to address.

[30] **Jenny Rathbone:** My second—

[31] **David Rees:** One second, I want to keep on the theme of the need for legislation. Janet, did you want to talk about the need for legislation? I'll come back to you, Jenny.

[32] **Janet Finch-Saunders:** Mine's on the strengthening of it as well.

[33] **David Rees:** Just keep to the need for legislation, if you can, in this case.

[34] **Janet Finch-Saunders:** Well, yes, it's all related.

[35] Kirsty, you know, right from square one, I've been very supportive of you bringing this forward. However, whilst we've been taking evidence, some of the comments that I've

picked up on are that this Bill doesn't cover all bases, that it's too narrow a focus, and then the unintended consequences for, you know, the care sector, for instance. But also are you looking to strengthen the Bill in any way, because of non-compliance? Because, even though you would be bringing legislation in, the Minister's letter that we've had maintains that he can do a lot of what you intend to do with this Bill using the acuity tools and using his own directions as a Minister, and what he can do as being mandatory. So, there are two sides to my question there, really: does the Bill go far enough? Does it cause unintended consequences in other areas? And then, also, about compliance to it, even if it became legislation.

[36] **David Rees:** You've answered much of the last one already, so—

[37] **Janet Finch-Saunders:** With all respect, Chairman, she hasn't.

[38] **Kirsty Williams:** I know that the committee will hear later from the nursing home care sector and I'll be very interested to hear what they have to say, and I know that Darren Millar has raised concerns about the independent sector. I am open to listening to that evidence and hearing what the committee has to say in that regard, but I'm very clear that my focus here is on NHS nursing care and creating that overarching duty.

[39] Because the health boards will have a statutory obligation, under this legislation, to have regard to the importance of ensuring that registered nurses are deployed in sufficient numbers to enable the provision of safe nursing care in all settings, if they did divert staff from other settings and, as a direct result, could not provide safe care because they had done so, they would be equally accountable under the law as if they had failed to meet safe staffing in the acute wards. My reading of the evidence that the committee has heard, certainly from the academic witnesses who have studied these models in lots of places, both internationally and in home settings—they gave evidence to the committee that they weren't convinced that legislation for acute areas would impact on other areas. I can understand why it would seem, perhaps, a logical assumption to make, like Jenny Rathbone has, but I don't believe we should let those fears undermine the prospect of legislating, because what we've heard from the people who've studied this stuff is that it doesn't happen. Plus, we have, in considering the Bill—because, initially, my first vision of it was it would simply be about hospitals. That's why we included the overarching duty to try and ensure that those unintended consequences did not happen. We've thought about that in drafting it.

[40] **David Rees:** Anything else on the compliance issue?

[41] **Kirsty Williams:** On the compliance issues, what I'm trying to do, Janet, is to create an environment of safe staffing, not to create a massive bureaucracy so that resources—both financial and staff resources—are spent ticking boxes and writing reports. What we're trying to do is to ensure that existing systems that would exist within local health boards are used to be able to demonstrate compliance. So, for instance, if people haven't got it already, all health boards are working towards e-rostering systems. My own local health board received money from Welsh Government just last week to ensure that they install e-rostering systems. Hospitals and local health boards should have access to these data and should be able to pull it off. In terms of compliance, we're trying to use the existing regime, not create an expensive regime on top of what we've already got. So, the Ministers have powers of intervention. We saw, just yesterday, the Minister make a decision with regard to scrutiny of Cardiff and Vale because of their concerns about failure to meet their three-year targets and then around unscheduled care targets. So, those systems already—. We're trying to use existing systems, rather than create an over-burdensome and overly costly system just to look at this. We're trying to use existing systems.

[42] Incidentally, if the committee decided that legislation wasn't necessary, and you were going to go with the Minister's power of direction, you wouldn't have half of the ability to

scrutinise the compliance and the impact than you would if you went down this route.

[43] **David Rees:** Okay, we've got Darren and then Lynne on this particular theme, and then we will move on.

[44] **Darren Millar:** I just want to ask you a little bit more about whether there's a need for further legislation or not. In the Minister's response to us, he's made it quite clear that he can issue a direction, and that that direction could be in the form of a letter, as you've suggested, or it also could be in the form of regulations that he could provide to health boards, which is, obviously, a different approach, which could be perceived as much more rigid. Your Bill, of course, will require legislation or mandatory guidance to be published, whereas the current legislation doesn't require things to be published, but it gives the Minister permission, if you like, to be able to publish new regulations, if he wants to. Given that that is the case, the Minister could, of course, publish regulations requiring certain information to be gathered and requiring it to be published in exactly the same way as your Bill actually does. So, if the Minister were to give a clear commitment and a time frame by which regulations would be introduced to require health boards to meet safe nurse staffing levels and not just take the acuity tool as the basis for that, but also look at other aspects, such as nurse qualification levels, et cetera, et cetera, and the skill mix on wards, et cetera, do you accept that there is perfectly sufficient legislation available already to the Minister to be able to deliver against your policy objective, which is safe nurse staffing levels on all acute wards across Wales?

[45] **Kirsty Williams:** First of all, I'm not aware, Darren, that the Minister has given any commitment with regard to regulations. My understanding also is—

[46] **Darren Millar:** Has hasn't—if he did.

[47] **Kirsty Williams:** My understanding also is, if he was to go down the regulation route, that would be a negative procedure and, therefore, we would have to—to get the level of scrutiny that I think something like this needs, then we'd have to be aware of that and we'd have to pray against those regulations. So, we'd have no chance of influencing those—it would be a 'yes'. Lisa might correct me, it would just simply be a—

[48] **Ms Salkeld:** They would come into force unless somebody puts a motion down to annul them.

[49] **Kirsty Williams:** So, again, our ability to influence that, I think, is less than what we have here, potentially, with the legislation. Again, what I'm looking for is for the legislature to have control of this process rather than an individual Minister, and to have a level of permanency that I don't think either directions or regulations would create—and they can't create that overarching duty, so what we've just heard from Jenny is a genuine concern. I can well understand why people would say, 'I'm worried that if we put more nurses onto our acute hospital wards, we'll have fewer nurses on the district, in the community'. We've thought about that in drafting the legislation, hence we have that overarching duty to try to mitigate any of those concerns that people have, and the regulations can't create that overarching duty that this legislation has. So, actually, the fears of people, like Jenny Rathbone has just articulated, which I'm not dismissing, are more likely to happen than they are under this legislation, because the Minister cannot, either by direction or by regulation, create that overarching duty on safe staffing for the local health boards. He can't do it.

[50] **Darren Millar:** You accept, though, that the Minister could voluntarily use a positive procedure, if you like, rather than a negative procedure to deliver regulations.

[51] **Kirsty Williams:** I'm not aware that he couldn't.

[52] **Darren Millar:** There've been regulations, of course, that have been brought to this committee that need not have been brought to this committee in the past, for example.

[53] **Kirsty Williams:** Lisa was explaining that, under the 2006 Act—

[54] **Ms Salkeld:** The Act lays down the procedure that the regulations will follow. The directions can just be in writing, which would receive no scrutiny, or they can be regulations via the negative procedure.

[55] **Kirsty Williams:** So you'd have to amend the—

[56] **Darren Millar:** The point I'm making is that the Minister could voluntarily consult with the committee, consult with the National Assembly and—

[57] **David Rees:** The point's been made.

[58] **Kirsty Williams:** He could, but then in terms of the Act that he would have to use—the 2006 Act, which would allow him to do either power of direction or the regulation—it does not allow for that.

[59] **David Rees:** Lynne.

[60] **Lynne Neagle:** Thank you, Chair. This does get to the heart of the matter, doesn't it? I'm in the same position as Janet: I've been very supportive of what you're trying to do throughout, but I was very struck by the Minister's evidence last week. But I'm as keen to get it—. If we were going to go down the road of saying legislation wasn't necessary, I would personally want to nail it down as much as possible, because I found that the evidence of the health boards, which was referred to in the advice note from the committee, deeply unconvincing. So, I just wanted to ask, further to Darren's question: is there anything that the Minister could do that would nail this down sufficiently for you to say, 'Well, no, we won't go with the legislation at this time'? I would be up for affirmative procedures and everything—I'm not keen on voluntary this and voluntary that. Is there anything that the Minister could make a commitment to that would satisfy you at this stage?

[61] **Kirsty Williams:** I want to put on record that I have a huge amount of respect for the Minister for Health and Social Services. He is a principled man and I'm sure that, if he gave his word, he would act on that. I don't want this to sound as if I'm casting aspersions on his character because I am not. But this is not about the commitment by an individual Minister, you know? Ministers come and Ministers go. Ministers' priorities can change, and the history of health policy in Wales for the last 15 years is littered with ministerial intentions, ministerial commitments, targets, standards, and all of those things we see not delivered on a daily basis. Perhaps we're willing to live with that, because I'm a realist, and we can't legislate completely for an NHS system. We can't do that. But what we know is that safe staffing saves lives and it reduces mortality rates. So, I think, if there is one thing that we should legislate for in our national health service, it's to legislate that the services are delivered by safe staffing levels.

09:30

[62] So, for me, this is about the principle, and a principle that goes beyond an individual Minister's commitment, that puts power in the hands of the legislature so that it does not have to rely on goodwill or persuasion or waiting for the Minister to do the right thing, but the legislature takes control and says, 'This is what we want', and mandates the Minister to do that.

[63] What we also know, Lynne, is that the Minister has made money available and health boards have made progress on meeting the CNO's ratios, but that doesn't really mean that it will happen in six months' time, and when the next big scandal comes along and the priority and the spotlight is shone on something else, we will all move on to something else. This creates a permanency that I believe cannot be replicated simply by letters of direction, or even by regulation.

[64] **Lynne Neagle:** I agree with you entirely about Mark, and I share your frustrations about the issues you've referred to about delivery over the years. But when I was talking about nailing it down, it's not nailing it down based on the commitment of one Minister. If, say, for example, the Minister were to commit to regulations that had to be done by a superaffirmative procedure or something like that, would that go some way to addressing your concerns? Can I also ask you about the reference to the Scottish Government's process? I'm assuming you've seen the note the committee's had, which is referred to in there, and whether you've got any knowledge of how effective that has been in terms of this.

[65] **Kirsty Williams:** It would be a step forward, and it would be better than nothing, but as I said earlier, the Minister can't by regulation create that overarching duty. He can't do that. The Minister has only given an indication on his willingness to look at the acuity tool, and I don't think that you deliver safe staffing levels by the mandatory use of the acuity tool alone. I think it needs to be a more sophisticated approach.

[66] With regard to the Scottish system, I know that the Scottish system has been welcomed. I'm not aware of the ongoing impact of that, although I know that people in Scotland are glad that that's happened.

[67] **David Rees:** I want to go to Lindsay, then I'll go back to Jenny, Peter and Janet. We'll go back to Janet and the unintended consequences question. So, Lindsay.

[68] **Lindsay Whittle:** Okay, thank you, Chair. At the very commencement of your opening statement—well, not statement but your answers to the questions—you talked about powers of direction. With the greatest of respect, powers of direction, different Minister or legislation, we have had a raft of evidence that there is a shortage of nurses. How would you address that, please? And if I could, Chair, because I'm not sure if I'm going to get it in later, I'd like to ask a question about the naming of the Bill—the Safe Nurse Staffing Levels (Wales) Bill. Is that a lawyer's dream and a health board's nightmare just in the name alone, please?

[69] **Kirsty Williams:** Okay. With regard to your concerns about whether we've got enough nurses, I believe that by placing safe nurse staffing on a statutory footing, the Bill aims—. One of the outcomes of the Bill would be to strengthen accountability for the safety, quality and efficacy of workforce planning and management. Because, like you, Lindsay, whilst I recognise that we've moved towards meeting the CNO's ratios, if you look at the evidence that you've received from Healthcare Inspectorate Wales, the CHCs and many other organisations, there is a feeling that we still haven't got safe staffing levels on our wards, despite what the CNO says about compliance with her guidance. So, I think, actually, the Bill would strengthen workforce planning to make sure that we were planning, training and recruiting the right number of staff. Because the best way for the local health boards to meet the statutory duties that will be placed upon them by the Bill would be to engage in long-term workforce planning, rather than what we do now, which is often flying by the seats of our pants, dragging people in off agency and bank to try and meet demands on an individual shift by shift basis.

[70] It's been argued that there's a shortage of nurses, but that's not necessarily a shortage of individuals with nursing qualifications; it's just that they're not choosing to practise. And

what we know from international evidence is that what lots of countries have done is to use mechanisms of this kind to actually bring people back into the nursing profession, and there is evidence to suggest that they've been successful in that. The 2013 report by the International Council of Nurses describes just that process; that countries have been turning to mandated ratios as a strategy to improve workforce conditions and to facilitate nurses to practise. The same was recorded in Linda Aiken's work regarding California. And, fundamentally, the Bill goes beyond just trying to establish it on a day by day basis, but actually creates, I think, the environment in which we could address some of those problems. But I don't disagree with you; we're going to need more nurses brought into the service.

[71] **Lindsay Whittle:** And the naming of the Bill?

[72] **Kirsty Williams:** The naming of the Bill. Initially, you'll be aware that I was going to call the Bill 'minimum nurse staffing levels' and as a result of consultation with the profession and lots of people, people said that that 'minimum' would not deliver the policy goal of creating a safe environment. So, we've changed the name of the Bill as a result of consultation because that's what we're seeking to achieve: safe staffing. A lawyer's charter, Lindsay, I don't know; it seems to me that if you ever put two lawyers in a room, you will get a difference of opinion and different views.

[73] **David Rees:** On the question of nursing, you believe that there would be a need for more nurses. Have you identified roughly a timescale whereby you think that would be a target of achievement, in other words the commencement date of the Bill, to be able to make sure that there are sufficient numbers of nurses to deliver?

[74] **Kirsty Williams:** I've listened to the evidence about that and if the committee felt that the commencement date had to be altered, I would be willing to look at that. I'm between a rock and a hard place because, on one hand, some of the evidence and some of the views from committee is, 'Oh, we don't need to do this because we're already meeting the chief nursing officer's targets' and on the other hand, the committee sometimes says, 'Oh, we can't commence the Bill when we need to commence it because we haven't got enough nurses to actually deliver'.

[75] **David Rees:** The committee is exploring all options.

[76] **Kirsty Williams:** Exactly. So, in some ways, the evidence is contradictory. The evidence that the committee has received is in some way contradictory in that regard. My understanding is that if the legislation was to go through the Assembly and be passed, it would not be able to be commenced until the following—

[77] **Ms Salkeld:** The April afterwards.

[78] **Kirsty Williams:** The April after the financial year, but I'm willing to listen to committee if it had views on commencement.

[79] **David Rees:** Okay; thank you. Jenny.

[80] **Jenny Rathbone:** Increasingly, the best medicine and the best outcomes for patients are delivered by multidisciplinary teams, so each bring their own skill to the party in the decision-making process. That's certainly embedded in cancer care, and is, in varying degrees, in other disciplines. One of the key issues raised from the evidence to the committee is from other health professionals who are saying that, by focusing only on nurses, we are undermining this multidisciplinary approach, which is also obviously central to the prudent healthcare approach of the Minister. I wonder if you could say how you think that is not the case.

[81] **Kirsty Williams:** The principle of multidisciplinary teams is one that I wholeheartedly support, and this legislation has never been for me about setting one professional group against another. But what I think we all realise is that nurses, and the role of nurses, is fundamentally different to other healthcare professionals, in the sense that it is only the nursing profession that is responsible for patients 24 hours a day, seven days of the week. Therefore, their contact with patients, and their ability to influence the outcomes for patients, is singularly unique within the health service. Doctors come and do their ward rounds, issue instructions and leave. Occupational therapists, physios and all those other professionals have an input into a patient, but in terms of providing 24-hour, around-the-clock care, the nurse is unique in that position. So, for me, it's not about setting professions against other professions, but I think what we do know is that the impact of unsafe staffing levels for nursing actually increases morbidity: people, potentially, are put at risk because of it.

[82] In terms of prudent healthcare, you will have heard from health boards that, actually, investing in safe nurse staffing levels is a good use of money. It's a prudent use of money and you get better outcomes for people. In terms of interaction with the multidisciplinary team, what we also know is that, if you've got nurses in the right numbers on the wards, that can be of benefit to the multidisciplinary team because they ensure—especially if the nurse in charge is freed up to be the nurse in charge, and isn't looking after eight patients as well as being the nurse in charge—that the patient gets to the physio on time and gets to the occupational therapist in the hospital on time, and they can facilitate the discharge, and can work with people back in the community to facilitate that discharge. Actually, having nurses in the right numbers in our settings helps those other professionals play their role more effectively. That, to me, is prudent.

[83] **Jenny Rathbone:** You make the case well, but do you understand that other professions, such as physiotherapists et cetera, are worried that if we invest more money in nursing, there will be less money for other bits of the service?

[84] **Kirsty Williams:** I understand, and I'm respectful of their view. I don't agree with it. I don't believe there's evidence to suggest that that would be case. I don't think it recognises the unique position of nurses, and, as I said, I think actually getting nurses in the right number is a prudent method and actually can have a positive benefit for other professionals.

[85] **David Rees:** Peter.

[86] **Peter Black:** I want to start by summing up my understanding of what you're saying in terms of the Minister's existing powers. What you're saying is that this Bill takes a strategic view, which goes beyond the existing powers of the Minister, but also adds transparency and accountability to the process, which isn't there if the Minister uses his existing powers. Is that a fair summary?

[87] **Kirsty Williams:** It's a very fair and a very accurate summary. Thank you.

[88] **Peter Black:** Thank you. So, if I can move on then in terms of how this Bill would actually work in terms of its introduction, I think concern has been expressed in evidence around compliance, given that we have a Bill that says, at some point in the future, you have to achieve safe nursing levels, but most people would say that that can't be achieved overnight and there has to be a process by which you actually move towards that in terms of recruiting more nurses, hopefully bringing nurses back into the profession and getting up to that level. So, how would you envisage the implementation of this Bill and the process towards getting to that safe nursing level, which you look to achieve if this Bill becomes law?

[89] **Kirsty Williams:** I preferred your first question. My vision for the Bill is, as you say,

that it creates this statutory principle, so I think that transforms the way in which individual health boards will start to focus on their workforce planning over a longer period of time, which will make it much more robust than it currently is. The academic evidence and the international evidence suggest that legislation of this kind actually does have that desired effect of bringing people—. First of all, it makes sure that local health boards create permanent positions to make sure that they know that they can deliver on their statutory obligations. It brings nurses back into the profession. That's the evidence and the experience from elsewhere where it's happened. I don't see anything peculiar about the Welsh NHS that would suggest that we would have a different pattern to that.

09:45

[90] Elin and Darren and some other Assembly Members were able to be at the cross-party group on nursing earlier on this week, and what was so powerful for me was to listen to a nurse in charge of a ward in Abertawe Bro Morgannwg. She said that what this legislation would do for her is strengthen her arm because, now, when she knows she needs more staff on her ward and she puts that further up the food chain—to ask for more staff—that is ignored. She's held responsible for the care on her ward, but her ability to deliver that care is often decided by people further up the food chain. She asks them for more staff, and they just ignore her. They just walk away and tell her to carry on and to do her job. This would strengthen the arm of those front-line staff. They would be able to turn to a piece of legislation and say, 'You have to: the National Assembly has said to you that you have to take this into consideration when you're making decisions about how many nurses you're putting on my ward'. I think that's much more powerful, if I may so, than any letter of direction or even—

[91] **David Rees:** You've said that several times this morning already.

[92] **Peter Black:** It's a very important point.

[93] **Kirsty Williams:** I think it is an important point.

[94] **David Rees:** Yes, but time is tight, and we need to move on.

[95] **Kirsty Williams:** Sorry.

[96] **Peter Black:** So, following on from that, in terms of the ministerial direction based on this Bill, if it becomes law, would the Minister therefore say to health boards, 'I expect you to comply with this Bill by X date', or is he going to take the view that this is a process that health boards will have to achieve over a period of time, and he would then just monitor that with the expectations that they would do so in due course? How do you envisage that working?

[97] **Kirsty Williams:** We would have to wait, because of course this is somewhat of a framework, so the Minister would issue the detail under regulations, and he would be able state in them his expected timescales for compliance within that.

[98] **Peter Black:** So, he would presumably work with health boards in terms of what they think they can do in terms of complying with this.

[99] **Kirsty Williams:** Yes.

[100] **Peter Black:** Right, okay.

[101] **David Rees:** Darren.

[102] **Darren Millar:** I just wanted to ask about compliance issues, if that's okay. You've already referred to the fact that there is plenty of guidance out there from the Welsh Government on the need to meet performance and the need to collate and provide information, and, frankly, the NHS isn't performing against that guidance particularly well in certain areas. How on earth, given that this is just a framework, can we be confident that it's actually going to make a difference on the ground in terms of delivery? The Minister has suggested that the suite of performance measures doesn't necessarily have a direct link to—or a number of them don't have a direct link to—nurse staffing levels and, as a result of that, he would like to see those stripped out. Do you concur with that? I mean, this is only going to be as good as it is policed, isn't it?

[103] **Kirsty Williams:** I agree. I think we need to have robust ways of ensuring that the desired effect of the legislation is actually being achieved. In my previous correspondence with the committee, I outlined that the indicators are in section 3, the review section, of the Bill, showing their relationship to nurse staffing levels, specifically that they have been identified through existing academic research, public consultation, existing NICE safe staffing guidance and the chief nursing officer's care quality indicators. So, we've tried to create a list there of things that we believe would be indicators that could be included to judge the effectiveness of the legislation. I know the Minister has some views about whether all of them are necessary, whether there can be direct causal effects linked to some them. I know readmission rates are his particular bugbear, but actually there are examples from research published in the Health Services Research journal showing that higher registered nurse staffing levels lower the probability of patient readmissions and unplanned visits to emergency departments—especially in the field of diabetes, actually, which is one of the areas where there is specific evidence. I'm willing to discuss with the Minister whether that list is exhaustive, but, as I said, the reason why the list is there is as a result of those factors.

[104] **Darren Millar:** You missed hydration and nutrition off the list. Any particular reason for that?

[105] **Kirsty Williams:** No. There's no particular reason for that. It certainly isn't something that has come up. As I said, the list is drawn up from existing academic research. Some of it was as a result of the first stage of public consultation. Some people suggested other ideas—existing National Institute for Health and Care Excellence guidance and chief nursing officer care quality indicators—but no, there's no reason why. If the committee felt strongly about that, I would look at the evidence to back the committee—

[106] **Darren Millar:** It's certainly in the 'Trusted to care' report, the Mid Staffs report, and in Sir Bruce Keogh's work, it features as an issue. So in terms of sanctions, then, against health boards, you simply provide a framework Bill here, so it's difficult to understand what sort of sanctions you think should apply to health boards. How do you see these emerging? I think there needs to be a bit more detail on the Bill about some of these issues, if the Bill is to proceed.

[107] **Kirsty Williams:** We did consult on sanctions, and I have to admit there was no consensus during the consultation on what a sanctions regime would look like. Some people, for instance, suggested fines whilst other people were very anxious that all fines would do was take money away from services that need that money. What we are trying to do, again, is to try and find a proportionate way of measuring the impact. So, you will be more than aware, Darren, than anybody else here on the intervention categories, the four categories that the Minister has at his disposal, and I don't want to create an extra regime on top of that. My vision would be that this would be part of the performance management of local health boards that Welsh Government would look at, and if they felt that it wasn't properly being done, then they could use the existing powers of intervention. Of course, what the Bill would do as well would be to create an opportunity for individual patients and patient groups actually to take

legal action or a group action, if they thought it necessary.

[108] **Darren Millar:** So you accept that litigation is a highly likely outcome of the Bill then, do you?

[109] **Kirsty Williams:** I don't say it's a highly likely outcome of the Bill. What I'm saying is that the legislation would certainly empower people to do that if there was a failing. My vision of the Bill would be that compliance with this legislation would form part of the regular monitoring of performance by local health boards, and that the Welsh Government and Welsh Ministers, if they felt local health boards were not performing in this regard, would use the existing intervention regime and mechanisms to hold the local health board to account.

[110] **Darren Millar:** Are you satisfied the existing intervention regime is working, then, in terms of delivering improvements?

[111] **Kirsty Williams:** Well, it's relatively new, the new four-stage intervention process. I think, at this stage, it's too early for any of us to make a judgment on that. What we have seen from the Minister is a willingness to use that intervention process, so we know that Betsi Cadwaladr University Local Health Board is currently at intervention level 3. We saw this week the Minister's willingness to use that with regard to Cardiff and Vale local health board, and I think we have to let this new system bed down before we make a judgment on whether it's adequate or inadequate. I am heartened by the fact that the Minister has not been afraid, actually, to use his powers of intervention and to call those health boards to account in a way that I have not seen used in the 15 years that I have been here before.

[112] **Darren Millar:** Can I ask one final question? We obviously receive reports from the chief nursing officer on levels of compliance across Wales—levels of compliance that have been reported to her. Clearly, health boards will do whatever they can to demonstrate that they are meeting any new mandatory guidance that may emerge as a result of this Bill. How confident can we be that, unless there's a good independent inspection regime attached to the framework in your Bill, we're really going to get a true picture of what nurse staffing levels are like across Wales? You mentioned the cross-party group on nursing meeting on Tuesday, and it was quite clear that there was a great deal of scepticism as to how much we could rely on the self-reporting from health boards in relation to this.

[113] **Kirsty Williams:** You will have seen, from the evidence, that there is certainly a disparity between official statistics and how it feels to people like Healthcare Inspectorate Wales, CHCs and other organisations who spend their time—. But, Darren, you know, we have to work on the basis that these are professional organisations, and we have to work on the basis that the information that they supply will be accurate. What we have tried to do here is create a reporting mechanism that strikes the balance between being effective and being overburdensome; I think we've struck that balance here. We have to work on the basis that local health boards, which are legally responsible, will actually give correct information, but what the evidence, I think, does show, and what we heard in the all-party group, is that you cannot rely on ratios alone to provide safe staffing levels. Therefore, when the chief nursing officer and local health boards report back that they are meeting their ratios, that in itself does not mean that we are staffing our wards at a safe level. Hence, this Bill is about the triangulated approach, because it is more than just a ratio; you cannot rely on ratios alone to say, 'That's adequate'. That's why you do need the acuity tool and the professional judgment, and I think that's what leads to the kind of disparity between hard statistics and how it feels on the ground.

[114] **Darren Millar:** There's a great deal of emphasis on ratios, though, isn't there, in part 5 of your Bill?

[115] **David Rees:** Okay; we'll come back to that one. Alun and then Elin.

[116] **Alun Davies:** Following Darren's line of questioning, in many ways, my concern with the legislation, as currently drafted, is that, without a significant sanctions regime within it, it fails the 'so what?' test. If you've got a ward that falls below a safe staffing level that is, in some way, defined in the legislation, what happens next? What is the consequence of that? You said in answer to Darren that we have to work on the basis that the national health service is run by professional organisations and good managers; I think that we do have to work on that basis. Nobody, to my knowledge or experience, has ever taken a decision that 'We are going to provide unsafe nursing levels on this ward at a particular time'; that's not a decision that's been taken, as far as I'm aware. So, you have a situation where you've got good people trying to do the right thing, and, if they fall short of doing the right thing, in terms of the correct mix of professionals, skills and numbers of people working on a particular ward, what is the consequence? As far as I can see, and, in answer to your question to Darren, there seem to be two consequences: one is the capacity to create headlines a few months later, when reporting is completed, and the second is the capacity to create a culture of litigation, and I think that Lindsay referred to this earlier as well. I've got real concern about that, because unless there is a significant structure of sanctions that can actually change and enforce different behaviour in a particular way, the only option available to people who feel that they want redress is through litigation.

[117] **Kirsty Williams:** The Bill provides, indeed, a statutory basis on which staff and patients could challenge unsafe staffing levels, both within the health service bodies and within the courts. So, without a shadow of a doubt, it allows people to seek redress in the courts if they wanted to. The powers available to the Minister, generally, in relation to the National Health Service (Wales) Act 2006, will also exist in this Bill, so that takes us back to the point where the existing legislation, which would also relate to this Bill, includes direction-making powers or, ultimately, intervening in local health boards. So, the Minister could intervene in that board. I'm not clear what else you would require the Welsh Minister to do; he has the power to intervene, sack the board and dissolve it. Ultimately, it is for the Welsh Minister to look at this legislation and say, 'Well, this organisation is completely wilful in its neglect and its ability to deliver against that; therefore, we need to intervene in that organisation'. I'm not clear what else, on top of that, the committee would like to see in relation to what we could do on compliance, because, ultimately, the Minister could take over the organisation and, actually, run the organisation if it was felt that it was that dire.

10:00

[118] **Kirsty Williams:** With regard to unsafe staffing, I think you're right—nobody deliberately set out this morning to provide unsafe staffing, but we tolerate it. We tolerate it and we've been tolerating it for a long time.

[119] **Alun Davies:** But your earlier answer to that question indicated that the Minister has a raft of different powers, and in answer to an earlier question you said that this Minister is intervening in a way that other Ministers haven't, and that's ministerial discretion. You said that Ministers will come and go and different Ministers will take different decisions. That's the nature of a democratic settlement. But in terms of this legislation, I don't understand how the actions of individual managers can be held to account without having a sanctions regime in place, except through the means that you've outlined in your answer, which I accept. But all of those powers already exist. We don't need additional legislation in order to deliver those sorts of interventions. Those powers exist and, as you've accepted yourself, those powers have been used in the last few days. So, would it not be a more realistic and proportionate approach to delivering on what I think we agree is required here that the Minister delivers on the statutory guidance, which we discussed earlier, and that this committee is able, in some way, to be satisfied that that guidance delivers the sort of regime that we would like to see on wards

across Wales?

[120] **Kirsty Williams:** What the Minister could not do via guidance or by direction, as I stated earlier, would be to create the overarching statutory requirement. He couldn't do that. You say, 'Well, the Minister could intervene now', but there is no statutory basis for him to intervene with regard to safe staffing levels, and they've not chosen to do this. This requires the local health boards to provide safe staffing and then it also allows for the Minister to intervene in relation to safe staffing specifically, and I think that is what is important. And I think that would not happen if we just potentially had powers of direction. I think that's what's different about it, because there would be a specific measurement of this particular aspect of healthcare in Wales. I think that's why the legislation is necessary, because we are tolerating unsafe staffing levels. We're tolerating it.

[121] **Alun Davies:** Well, the fact that we are having a series of debates would indicate that we're probably not, in fact, but that's a different point.

[122] **David Rees:** Can we move on? I'm quite conscious of the time and I've got Elin to come in. Do you want to add anything more to that?

[123] **Alun Davies:** We can continue this conversation.

[124] **David Rees:** Elin.

[125] **Elin Jones:** Yes. Two issues: first, on unintended consequences, my main concern from listening to the evidence is that other health settings where LHBs employee nurses directly may well find the nurses there dragged into adult in-patient wards in acute hospitals in order to meet the statutory obligation. I'm thinking in particular of community hospitals and their adult in-patient wards. I was wondering whether you have a view on whether this legislation would be strengthened and that unintended consequence avoided if it was amended to be adult in-patient wards in all LHB hospital settings, including community hospitals.

[126] Then, on the Minister's evidence on minimum ratios as set out on the second page of the Bill, there is some confusion as to what he meant when he was suggesting that, if this Bill progressed, he would want to see aspects of it taken out. I thought he actually meant that he wanted all references to minimum ratios taken out. There is a school of thought that says he meant just reference to 'minimum' rather than 'ratios' being taken out. I'm assuming that, if all references to staff:patient ratios was taken out, you would object strongly to that, because that is the core of the Bill, but would you have a view on whether the description of 'minimum' for those ratios should be amended, taken out or changed to 'safe', as we've also heard from the Royal College of Nursing?

[127] **Kirsty Williams:** Thank you. I think it's important to emphasise that the Bill does not require an artificially high level of nursing on acute wards. All it requires is the right level of nursing on acute wards. This is not about artificially inflating the number of nurses that are on those wards and, therefore, dragging them off from other places. It's about having the right number on those wards.

[128] The reason why the legislation is framed as it is, with regard to acute settings, is because that responds to the area where there has been the most public concern, where it is acknowledged there is the greatest problem. We have tried to, not futureproof but ensure, in drafting the legislation, that the Minister was able to bring forward guidance in other settings, whether that might be in community hospitals where, personally, I'd like to see lots more of our care delivered, especially for our elderly population—I think that would be more appropriate—or also in the community, responding to the point that Jenny Rathbone made earlier about care, and how we deliver care, moving out into the community. We know that

people are working very hard at the moment on what an acuity tool would look like in the community. The legislation is drafted in such a way that, when that evidence becomes available, the Minister can make regulations in that regard. But I'm willing to listen to the committee with regard to whether the Bill should be extended to other settings at this stage. I am not opposed to that at all.

[129] With regard to the Minister, my reading of what the Minister said was that he was concerned about the word 'minimum'. For me, ratios are an important part of the triangulated approach. They're certainly not the be-all and end-all in achieving safe staffing levels, but they are one of the elements that need to be taken into consideration. I will continue to listen to the Minister and the RCN about what they would regard as perhaps a more appropriate word to go in front of ratios. But I do believe the concept of ratios is an important one in helping us get to what is the overarching aim of the Bill, which is safe staffing.

[130] **David Rees:** The last question to Lynne.

[131] **Lynne Neagle:** Just on unintended consequences; one of the concerns raised is that health boards might consider closing wards if there was a danger that they might not meet the legal requirement. Have you got any response to that? On closing or removing beds.

[132] **Kirsty Williams:** Well, what I would hope is that we would encourage a more strategic and robust approach to workforce planning. I think that would be one of the consequences of the Bill, in that LHBs would have to be much more strategic in how they plan their staff, rather than how they do it at the moment, which I think has led to some of the challenges that we see in our hospitals. I'm not aware, from the evidence that's been given certainly by academics who have studied the consequences of similar legislation, that that has been the case. As I said, I don't see anything different in our system that would suggest that that would happen.

[133] The Bill is framed so that LHBs would have to demonstrate that they'd taken all reasonable steps. I certainly don't envisage the Bill being used as in the famous Briton Ferry bridge example: that, if a nurse got stuck on the Briton Ferry bridge as she travelled to work and the ward found themselves one down, that would be the reason why the ward would have to be shut or beds removed from that ward on that day. It would allow for that incident to be logged. What we'd be looking for, I think, is patterns of behaviour over a period of time. Again, the evidence we had from the all-party nursing group was that, actually, you could log that incident—that staffing was unsafe for that day—and if you found that those reports were being put in and there was a pattern of non-compliance and concerns about safe staffing levels, it would then strengthen the arm of the nurse in charge on that ward to demonstrate to the hierarchy, 'Actually, we have a problem here: it wasn't just a one-off because somebody got stuck on the Briton Ferry bridge; I'm having to put in these reports on a daily or weekly basis'. That would then strengthen their arm to make sure that people further up the hierarchy took action.

[134] It's interesting, Chair, that the Minister's approach to the Regulation and Inspection of Social Care (Wales) Bill that's coming forward with regard to social care is that he wants to place responsibility not just on the care manager in a particular setting, but actually, he wants to make the people above—the people who make the financial decisions—responsible, because that impacts on the ability. This is what this Bill tries to do; it is trying to say, 'Actually, it's not about just blaming nurses on wards now, because you've not done the right thing', it is actually putting responsibility at an overarching LHB level that says, 'You have to get your staffing right'.

[135] **David Rees:** I've got two final points before we finish. The example you've just highlighted about the Briton Ferry bridge, which we often see busy, but there you are—

[136] **Kirsty Williams:** No. It's the example that Mike Hedges used in the first debate.

[137] **David Rees:** But the question I want to raise is: is that a legislative problem? Whilst you've just identified that you'll be waiting for patterns—[*Inaudible.*]—what would an individual who takes legal action against any health board take as a consideration, because, on a day, in an instance, there are unsafe—in your regulations—staffing levels? Is that a legislative problem that we could be facing?

[138] The second question I want to ask is on costings. In light of all the evidence that's been received by the committee, have you done a reassessment of the financial impact of the Bill, particularly as we've been informed that, to meet some of the demands, there may be a higher demand for agency staff in the short term?

[139] **Kirsty Williams:** What the Bill requires is the LHB to be able to demonstrate that they've taken all reasonable steps to comply with safe staffing. I think that's an important principle. With regard to costings, no, we haven't done any reworking of them. Because of the framework nature of the Bill, what the costings in the documentation we've supplied to date focus on are the one-off costs surrounding compliance and maybe IT systems that would have to be put in place to deliver on the compliance element and the reporting element of the Bill.

[140] You'll be aware that the Minister has made available additional moneys to local health boards to ensure that they are compliant with the CNO's recommendations, and, again, there is conflicting evidence, because, on one hand, we're told, 'Ah, well, we're 95 per cent compliant with CNO guidance', and then we have local health boards saying, 'Oh, we'll need loads and loads of extra money for staff if we're to—'. So, we can't have it both ways; we can't be compliant on one hand and then say, 'Oh, no, we can't afford to do this, because there're going to be loads and loads of extra nurses we need to make us compliant'.

[141] **David Rees:** But you could be compliant because you're using agency staff.

[142] **Kirsty Williams:** What's also interesting is that we've never claimed that there would be cost savings as a result of this Bill, but I do believe—and the evidence from the LHBs suggested—that, actually, this is prudent investment. Actually investing in staff is a prudent way of spending health services' money, because you get a return on it and potential savings and you don't miss out on the opportunities of what safe staffing brings in terms of length of stay, falls, medicine mistakes, litigation.

[143] **David Rees:** Okay. Thank you for that and can I thank you for your evidence session this morning?

[144] **Kirsty Williams:** That's okay.

[145] **David Rees:** As you know, you'll receive a copy of the transcript for any factual inaccuracies you may wish to let us know about. Normally, this session would be the last session of Stage 1, but, as you're aware, we have a final one later on this morning. Once again, thank you very much for your time and thank you to your team.

[146] **Kirsty Williams:** Thank you very much.

[147] **David Rees:** I suggest we have a five-minute break.

Gohiriwyd y pwyllgor rhwng 10:13 a 10:20.
The meeting adjourned between 10:13 and 10:20.

Sesiwn Graffu ar Waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Iechyd: Gwaith Craffu Cyffredinol ac Ariannol
Scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: General and Financial Scrutiny

[148] **David Rees:** Can I welcome Members back to this morning's session? The next item on the agenda is our general and financial scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health. Can I welcome Mark Drakeford, the Minister for Health and Social Services, and Vaughan Gething, Deputy Minister for Health? Minister, would you like to introduce your team?

[149] **Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (Mark Drakeford):** Diolch yn fawr. Mae criw ohonom yma y bore yma—y prif swyddog meddygol, Dr Ruth Hussey, Dr Andrew Goodall, prif weithredwr yr NHS yng Nghymru, ac Albert Heaney, sy'n arwain ar wasanaethau cymdeithasol.

The Minister for Health and Social Services (Mark Drakeford): Thank you very much. There is a big group of us here this morning—the chief medical officer, Dr Ruth Hussey, Dr Andrew Goodall, chief executive of the NHS in Wales, and Albert Heaney, who is leading on social services.

[150] **David Rees:** Can I thank you and welcome you all? And can I thank you, Minister, for the quite detailed report we had from you for evidence for this session? It obviously gives us a lot to think about and a lot of questions to raise. If we start off with questions straight away, we'll start with Gwyn Price.

[151] **Gwyn R. Price:** Thank you, Chair. Good morning, everybody. What outcomes does the Minister expect the 'Add to Your Life' programme to achieve, and what evaluation of the programme has been undertaken so far, and how will the effectiveness of the programme be measured and monitored going forward?

[152] **Mark Drakeford:** Thanks, Gwyn, for that. So, these are the health checks for the over-50s, which is in the Government's programme for this Assembly term. In terms of outcomes, I think what I'd look to the programme to do would be to produce a better informed group of patients of that age, better able to obtain the information that they need to be able better to look after their own health in the future. I think those would be the two key outcomes for me—better informed and better able to manage their own health conditions at that period in their lives. In terms of evaluation, and evaluation was built into the programme from the outset, phase 1 of the evaluation programme, which was an informative evaluation, was published, I think, back in January, so that's now in the public domain.

[153] Looking forward, in the third part of your question, what I would like to see the system do in the future would be to develop—. A lot of investment has gone in now to creating the platform, so we have the website, it's been very well developed, it was developed particularly in 10 Communities First areas to begin with, to make sure that it is genuinely accessible to people. We advertise it by writing to patients as they turn 50, so that they're aware of it. There have been about 13,000 uses of the website so far and about half of those lead to people completing the full questionnaire that's available to you. What I'm keen for the website to do in the future is to link into the information that third sector organisations in particular provide. We've had some very productive meetings recently with a group of third sector organisations, who came to Welsh Government to say, 'We spend a lot of money on producing patient-facing information about the conditions that we are interested in; we spend a lot of time testing it with patient groups to make sure that it's usable and accessible to them, but we struggle sometimes to get that information into the hands of the patients that we want to influence'. [*Inaudible*.] I think making sure that the website links clearly to those more

specialist forms of advice available through third sector organisations will be our next step in making it useful to patients.

[154] **Gwyn R. Price:** Just to follow up on that, Minister, I've had representations from my constituents where they thought in the beginning that they were going to get a health check from their GP. Do you think that was the intention in the beginning in the beginning, or was it unintended?

[155] **Mark Drakeford:** Well, I'm certainly glad that it hasn't turned out that way, because I think the one thing that we absolutely do not want to do is to have our GPs spending a lot of time seeing people for whom there is no need for a GP to be seeing. We've seen some interesting stuff recently. I'm sure that Members here will have seen the report—I think about 10 days ago now—of memory clinics in England, which have been overwhelmed, as they put it, by people who have no need to go to a memory clinic, but, because they are maybe just slightly anxious about the state of their own recollection, instead of using the parts of the system that they ought to be using, they go straight to a memory clinic, which are now not able to see people who they really do need to see.

[156] So, we've got to design a health world in which people go to the right place for the information that they need. The over-50s health check wouldn't, I don't think, have been a success at all if it had resulted in an awful lot of people who didn't need to see a GP trying to get to see a GP. Instead, the website offers you very clear advice and a very structured way of testing all the things you might want to test. It would give you guidance if the result of the test was that you should see a GP, but, for the vast majority of people who use it, it will simply provide them with information to help them to manage their own health condition better.

[157] **David Rees:** Just out of curiosity, Minister, you've updated the figure in your paper from 5,000 plus to 6,000-odd now. What percentage target were you expecting to hit, because, if you look at the number of people who actually reach the age—? I think you identified that 42,000 each year reach the age of 50, therefore that's 11 per cent or 12 per cent of that figure.

[158] **Mark Drakeford:** I think the ambition for the website is to grow the number of people who visit it and use it. We have to find reasons for people to go back to it and not just use it once and think they've done that. We're talking with the system about whether the letter to someone at the point that they turn 50 is actually the most effective way of driving traffic to the website. Might there be better ways of doing that? So, it's a reasonable start, but I think the website—. I've used it. I've been through the whole questionnaire and so on. I think that it's got a wider applicability to people and we will aim to get more people using it.

[159] **David Rees:** Alun.

[160] **Alun Davies:** You talk about the pressures on GPs. I'm interested in that, Minister. I'm aware that the Royal College of General Practitioners this week called for pharmacists to be based in GP surgeries in England in order to help reduce some of the pressures across there. Can you, perhaps, talk us through what is being done in Wales to reduce the burden on GPs here?

[161] **Mark Drakeford:** Thanks to Alun for that question, because it's a really fundamental part, I think, of the way that we see primary care being provided in the future. Anything up to 40 per cent of consultations that GPs have during a standard working morning we know could equally, clinically, effectively be discharged by a different member of a wider primary care team.

[162] Our GPs are our most highly trained and our most senior people in the primary care team and we have to make sure that they are able to use their time seeing those more

complicated cases that really need a GP to be in charge of their clinical care. And we have to free up their time to do that by diverting some of the other appointments that currently go to a GP to other people who can deal with people. We've had the idea of clinical pharmacists in Wales for at least the last 12 months. I've been talking actively to the Royal College of GPs about them. I'm very pleased to see them now advocating it themselves.

[163] Our view of it is to have a clinical pharmacist as actually a member of the primary care team. So, you know that we have this Choose Pharmacy campaign in Wales. It has 26 different conditions. If you phone up a GP practice and ask for an appointment to come in to see a GP about your verruca, the idea is that you're told, 'Well, you don't need to come here for that. You can go to the pharmacist and they will be able to prescribe what you need for that much more quickly and easily.' Well, a different way of doing that, instead of trying to persuade people to go to the pharmacist, is actually to have the pharmacist in the primary care team itself. So, people would just be given an appointment, in the way that they are now, but given it with somebody who is able, clinically and competently, to prescribe what they need without the GP needing to see them.

10:30

[164] Obviously, there is a wider group of people beyond clinical pharmacists. I think the primary care of the future will be provided by that wider group of professionals, all working at the top of their professional licence, led by GPs with responsibilities for professional standards, quality of care and for seeing those people whom only GPs are properly qualified to see. It was very encouraging to see the royal college endorsing part of that approach.

[165] **Alun Davies:** I very much agree with that vision, Minister. Where do you think health boards are now in terms of actually delivering that on the ground in different parts of Wales?

[166] **Mark Drakeford:** I might ask Dr Hussey to say something on this, because she's been out there, talking to different health boards. My impression of it, Alun, is that, where the traditional model of GP practice is still working reasonably well, there is sometimes a bit of resistance, in primary care, to this idea of diversification. But in parts of Wales where we know we have recruitment issues, then attitudes are changing already and we're finding GP practices welcoming the idea of their team being strengthened by other players who are available, can be recruited and allow GPs to go on providing a service, but Ruth may have some practical examples of where we know that's happening.

[167] **Dr Hussey:** There are examples already happening in Wales, where pharmacists are much more integrated into the clinical team. If you bear in mind that about a third of the population in Wales have chronic illnesses and about half the population are on treatments of some sort, then medicines is a major part of a primary care team's work. So, they can play a wide range of roles, both in terms of clinical contact, but also helping and checking, medicine usage reviews. As we get older, with complex, multiple illnesses as well—because people don't have one chronic illness, often they have several—the importance of making sure we've checked for polypharmacy and questioning that mix, all of that routine work can also help to balance the work of a practice.

[168] So, I've heard from one practice that does this sort of model. I know others that are saying, 'We'd really like to go into this area'. We've talked about it in the context of preparing our primary care workforce plan. Our conversation with GP leaders shows that there's a lot of interest in diversifying the workforce, and not just with pharmacists, but advanced nurse practitioners as well—so, really trying to create a strong team, properly targeting people into either acute illnesses that need the diagnostic skills of doctors or routine follow-up assessment, quality checks and so on. So, a real opportunity to expand. It's not widely available now, but some teams are getting there and others are starting to explore this

sort of model. We hope, when we produce the primary care workforce plan very shortly, it'll be a chance to have a conversation with the service about the mix of staff that we might then start to develop and grow for the future. I was very interested to see the RCGP report this week.

[169] **Alun Davies:** Thank you. You gave us some numbers there, at the beginning of your answer, Dr Hussey, that I think are very striking and shocking in terms of the number of chronic illnesses and people receiving treatment in Wales. Would it be possible, perhaps, for the Minister to drop us a line, a note or a short letter on some of those numbers—a statistical background, if you like? It would be very useful, I think, in terms of the public health Bill work that we're going to be doing.

[170] **Mark Drakeford:** Yes, by all means.

[171] **David Rees:** Jenny Rathbone on this point.

[172] **Jenny Rathbone:** I just want to follow up—I'm sure the pharmacist in the primary care practice works very well when you've got a sufficiently large practice. How are we delivering that sort of service in the small practices that are a feature of a lot of our practices?

[173] **Dr Hussey:** I think this is where the whole approach we've adopted through the primary care plan, which is to create 64 clusters—networks of primary care teams coming together, to start really looking at matching services to needs—. I'm very conscious, and I think I've said it in this committee before, that, you know, the needs of an inner-city urban population will be different and will be met in different ways to those of one that is very rural—a different age mix, a different profile of needs and so on. So, the idea of these clusters coming together is for practices to say, 'Well, we don't need all of that in every practice, but actually, if you look at a bigger population, we need at least one person who can do that for a slightly bigger area of our health board'. So, we're actively promoting that. You'll be aware that Ministers have identified resources to go directly to the clusters to start developing that approach, strengthening what they see as the particular things they need across a number of practices. It's early days, but there are encouraging signs that some clusters are really starting to get more partnership understanding, starting to work more across a number of practices, trying to think through what they need for their population. So, the risk that we have is we say, 'Well that's the standard model, and everybody has to have exactly the same mix of staff'. I don't think we can do that. What we can be clear about is the types of expectation we have, the sort of principles that drive that, and we really need front-line staff to work with local communities to work out the best mix that suits the needs of that local population.

[174] **Jenny Rathbone:** So, given that GPs are independent practitioners, what levers do health boards have to ensure that everybody's embracing this cluster arrangement?

[175] **Dr Hussey:** Well, the first thing is that, as contractors, they have a contract, and I'm pleased, and you'll be aware, that we have agreed a contract for the next couple of years with GPs in Wales, and part of that, actually, is freeing them up to do more of this type of work—so, an expectation as part of being a practitioner in Wales that we will see evidence of working together as clusters, there will be a plan, they will work in networks, and also, removing some of the quality points approach for administrative tasks, to free them up to do the sort of work that we think is important in those local communities. That's one avenue. The other avenue is the resources that have been made available to support clusters to do this work as well, additionally to that. So, I think every opportunity that we have to encourage people to come and participate in that sort of approach has been made available to them.

[176] **David Rees:** Lynne.

[177] **Lynne Neagle:** Thanks, Chair. I've got two health questions and then some questions on social services. The first is in relation to the 'Trusted to Care' spot checks. I'm very pleased that they've continued, and I'm particularly pleased to see them going into older people's mental health wards. Although they found areas of good practice, they did identify some shortcomings, including some that people I think would find surprising in older people's mental health wards, such as dementia friendliness. I just wanted to ask the Minister what steps are going to be taken to address those shortcomings, and also when—I know that you've committed to publishing the report—when you expect those to be published. Shall I ask all the questions at once?

[178] **David Rees:** The three health questions, yes.

[179] **Lynne Neagle:** Okay. The other was in relation to the ambulance handover policy. Again, I'm very pleased to see that in place, but I wanted to ask—I know it's fairly new—how that's being monitored by Government. And just finally on vaccination, I'm very pleased to see that a tier 1 priority, but the report makes reference to performance on the first MMR jab, and I just wondered if there's any update on how we're doing on the preschool jab that children are meant to have, because traditionally that's been the one where take-up has trailed off a bit.

[180] **David Rees:** Minister, obviously, which ones will you be responding to?

[181] **Mark Drakeford:** I'll take the spot check one, and Vaughan will do the ambulance one, and we might ask Dr Hussey just to give the specifics on the second MMR vaccination. So, as Lynne has said, we've followed up the spot checks that we carried out into the care of older people on general hospital wards with a second programme of checks on the care of older people in mental health settings. Twenty two different wards were visited. We used the same basic approach as we had in the first round—that is to say, to get a team of people together with specialist expertise in that area. They were all unannounced spot checks. They happened at all times of the day. In addition to the questions that were asked in the general spot checks to do with nutrition, hydration and so on, we added four other specific areas of concern into the mental health context: so, the use of restraint; the involvement of family members; the availability of activities during the day for people who are living on the ward; and then the quality of leadership. Kirsty and I went to one of the wards that had had a spot check in Llandrindod hospital last week.

[182] **Kirsty Williams:** They were surprised.

[183] **Mark Drakeford:** They were. They were surprised to see us, because we hadn't told them that we were coming, either, and it was very interesting to hear from the staff themselves how they really did get a spot check with no notice at all and how they coped with that at a time when several other parts of the ward were under refurbishment and everything like that. You got the impression, I felt, of a very rigorous approach to it. How will we follow it up in terms of the issues that were identified? Well, we're going to create a new community of practice amongst people who work in that particular field, because one of the things we feel we must do is to share the good things that came out of the report with some other places where things were not as good as we would have liked them to be. Very often, the explanation comes down to the environment. We were lucky enough to see a ward that was completely refurbished and where there was lots of good space. Where you had someone who had a problem with dementia and who might become a bit upset or agitated, there were lots of other places in the ward where that person might be taken, where they would get a change of scene, a different set of stimulation, and the report to us was that that was very effective in helping to manage people through some of the difficult times in the day for them. So, we want to share that across Wales. We'll create this new community of practice amongst practitioners at ground level, and we're optimistic that that will be a significant help in making sure that the

good things begin to happen everywhere.

[184] We are committed to publishing all of the spot checks together in a national report. We're not very far-off having that ready, but it's quite a bit of work to make sure that you collate everything into one coherent document. I'll make sure that committee members are alerted to the publication as soon as it's available.

[185] **David Rees:** Deputy Minister.

[186] **The Deputy Minister for Health (Vaughan Gething):** Yes. Thank you for the question, Lynne. On ambulance handover policy, you're right that a new policy was introduced towards the end of February. What's interesting is that that was drawn up by the unscheduled care board, working with medical directors and nurse directors in each of the health boards, as well as the ambulance trust, because this has been a regular cause for concern about the number of lost hours, what that means in terms of inefficient use of resource and money, as well as what that means for the patient as well and the overall impact on ambulance performance. So, we're also able to identify that there are particular pinch points within the system. Three hospital sites account for nearly 50% of the lost hours across Wales, so there are particular challenges about broader patient flow. Now, the new policy should help to deal with that. Within the first few weeks of seeing that, we can see that there's been a reduction in lost hours. There was a reduction from January to February in any event, and within this month I expect that we'll see further improvement as well.

[187] In terms of the oversight that we expect to have, I recently had a meeting with the lead chief exec for unscheduled care, Adam Cairns, with Tracy Myhill, the chief exec of the Welsh Ambulance Services NHS Trust, and also the ambulance services commissioner, because I want to have a regular hands-on approach to understand what's happening and how this guidance is actually being implemented in practice. We see lots of good practice across the system and in particular on patient flow in Cwm Taf, where they're still ahead of everybody else. On handovers, they don't really have a handover problem, and it's for the rest of the country to catch up and mirror their practice and to see that become standard. Now, the new handover policy should help to make that happen, and there is an understanding by the LHBs, when an ambulance turns up, that that patient is their responsibility and that it isn't just a case of leaving them in the ambulance to wait until they come through the door. So, I think there's a greater sense of shared ownership and understanding of their responsibility. As well as my own interaction, there is regular oversight from the chief executive of the NHS and the deputy chief executive in terms of the conference calls they have and the regular conversations they have with health boards. There's plenty of visibility on the issue.

[188] From my point of view, it's important that we now see an improvement in reducing the number of lost hours and then what there is in terms of the whole-system performance, not just on response times, but also in terms of patient outcomes, because that's what I'm really interested in. Reducing the handover delays should mean there are better patient outcomes at the end of it, and that's what I'm really interested in seeing and demonstrating. Dr Hussey is going to deal with the vaccination point.

[189] **Dr Hussey:** The question was about MMR specifically. I think the general picture with vaccination is a continued strong focus on this and very robust performance by the NHS in Wales, which I fully appreciate. If I look at the annual figures for the year 2013-14, the first dose MMR measured at age two, which is the measure we use, was 96.5 per cent. So, it was pleasing to see that we got there. Obviously, we must keep a focus on that. On uptake at five years, just under the 95 per cent; it was 92.6 per cent in 2013-14, but the confidence in the vaccine in those early years is strong.

10:45

[190] Now, the group we have discussed before, the teenage years, was where we really wanted to catch up on the low rates that had happened many years ago. Again, in the period 2013-14, the first dose uptake on MMR in 16-year-olds was reported as 94.6 per cent. So, it's encouraging that we've actually really got to that group. The second dose was not quite at the 95 per cent mark, but was about 88.6 per cent. So, we're not giving up on that group. We've got to keep focusing on making sure that that teenage year group is captured at any point in time through the school year, or when they come into services after they've left school, and that we try to keep that momentum up on that later group. But it's a huge step forward, and our focus now is really on keeping the momentum going.

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

[192] **David Rees:** Before you go on to the social services questions, Darren, do you want to come in on the ambulance?

[193] **Darren Millar:** Yes. I just wanted to ask about the ambulance service. You suggested that Cwm Taf is a shining example of how the ambulance service should operate in terms of transfers, but of course it has the worst-performing time against the 65 per cent target for category A calls. So, why is that? Why is it so dire?

[194] Perhaps you could also comment as well on the appalling costs associated with taxiing people to hospital. We heard just this week, didn't we, that it's costing around £900 per patient for the innovative taxi scheme, which is being piloted at the moment in Cardiff and the Vale? Is that an appropriate cost, do you think? Do you think that's good money for the taxpayer?

[195] **Vaughan Gething:** I'll deal with the two points separately. There's a clear recognition from everyone who's examined ambulance performance that handover, the best level of achievement, and the most rapid level of achievement is in Cwm Taf. Its overall performance is affected by the whole system. So, broadly, we know that ambulances at the moment get dragged down towards larger centres, and so, the performance of Cardiff and the Gwent, in particular, affect not just Cwm Taf but parts of Aneurin Bevan as well. The point is that we expect that improving handover in other sites will help to have more vehicles available more rapidly to go to the next call, where somebody's life could potentially be saved.

[196] Now, the challenge about how you ensure that the ambulance resource gets back to where it should be is not just something that affects Cwm Taf—and I know that Members here will have their own issues that they would raise on a very local level—but that's why we're taking a whole-system look at ambulance performance. I know that in your recent evidence you've heard the range of different issues that the service faces, the link between the ambulance service and health boards in terms of commissioning, and what each part of the system does, and in particular, issues around staffing and rostering. So, the handover is one part of it. As I said in answer to Lynne Neagle, I'm really interested that we focus on patient outcomes, because the work that we're doing on different measures that affect stroke, cardiac arrest and falls, particularly broken hips or fractured neck of femur, means that we're able to demonstrate that the treatment that paramedics provide makes a really big difference. There's this ongoing question of response times being the only measure that we apparently have for the ambulance service. It only monitors how quick somebody arrives, and not the quality of care that's then delivered. So, there's a broader conversation for us to have, but we do need to get the handover policy right as part of that.

[197] I'm pleased, actually, that you raised the point about taxis that was broken yesterday on Radio Wales initially. It was very unhelpful and really not a fair or accurate presentation of the picture. It conflated the difference between non-emergency patient transport and

emergency transport, and I don't recognise the average cost figure you've referred to. Part of our challenge is how we ensure that we get emergency ambulance services right in terms of an appropriate response in terms of time, and then the treatments provided, and then, for the non-emergency service, how do we get that right as well? You'll be aware that the McClelland review set out a different form for non-emergency transport, and the Minister and I have been very clear that we want to see some urgency injected into how that new form of organisation is created. In doing that, there are going to be different players within that. I'm really interested, for example, in community transport. I recently met with the Community Transport Association. I spoke by video to their conference. I think they've got a real role to play, and it's about how we plan that in for the non-emergency service. I've also had interesting correspondence from renal dialysis unit patients. There's a clinical need for them, who are very different to other people, but they're not emergency transport. Looking at all the different parts of how the system works is important, and the taxis are part of the solution. You don't need an ambulance to convey you if there is no clinical need for that. We have to understand how each part of the system works, what the cost is, and then the overall picture. I don't think that the story yesterday and the way it was presented was really very helpful or a fortunate way to go about it. I just don't accept that it was 'appalling'. I think that's very, very unhelpful.

[198] **Darren Millar:** I have no problem with innovative solutions being used in order to improve the capacity of the ambulance service. If somebody can be taken in a different way, which is safe, to a hospital, if they need to get there, I have no issue with that. What I think many people will have found extraordinary was the costs associated with ferrying a relatively small number of patients. As I understand it, the costs have not been disputed by the ambulance service. You seem to be disputing them now. If it's not around an average of £900 per patient on that pilot scheme in Cardiff, what is it?

[199] **Vaughan Gething:** I can provide more detail on the scheme, but I really think it's important to set out that just to attack one scheme on the figures that were issued yesterday is not a helpful way to discuss non-emergency transport. The important thing to recognise is, the way it was presented yesterday, it was as if that scheme was replacing the emergency ambulance service, in some of the reports that were used, and it isn't. I think it's important to put that on the record.

[200] **Darren Millar:** I'm not responsible for the BBC, but I'm responsible for asking the questions of you, Minister, about the performance of the ambulance service.

[201] **Vaughan Gething:** On the issues being raised, I think it's important to be clear that what was said yesterday wasn't accurate. In terms of the pilot, I know Dr Goodall is going to come back to give you some more detail on the specifics of it.

[202] **David Rees:** Dr Goodall.

[203] **Dr Goodall:** Just to focus on the Cardiff pilot that we've been extending more broadly, 112 patients are going through that. The intention is to make sure that we are able to offer an alternative mode of transport when the emergency vehicles are not there. The typical cost of that is around £183 for the ambulance journey itself. The taxi services that were used for this particular cohort of patients, so very precisely on these, were showing a range of different costs, which were appropriate taxi rates. The average was about £23. It operates at about 12 per cent of the cost of the emergency journey. What it allows for is for the paramedic to have a discussion about the lack of a need for an ambulance vehicle. We are mindful, within the pilot that took place, that there will be people who have problems accessing transport potentially, particularly from some of our most deprived communities. So, it is important still to make sure that hospital access can occur, but paramedics actually exercise the choice to make sure that they can signpost people to this service. It's been broadly

welcomed, actually, by the paramedic staff as an opportunity for them to step away from some of these services. Ambulance services are dealing with around 0.5 million calls a year, and we just to need to make sure that there are a range of different ways of ensuring that people can access these particular services. This is action by a paramedic in response to a 999 call that has occurred when they're at the scene but then they're able to deploy a different resource.

[204] **Darren Millar:** As I say, I have no problem with the scheme. It's a shame that the ambulance service weren't able to provide information on actual costs associated with the pilot scheme yesterday, I think. It is disappointing that their communications team have not been able to dispute the information that's been bandied around in the media.

[205] **David Rees:** Okay, you've made the point. Kirsty, on this particular point?

[206] **Kirsty Williams:** Yes. My concern about this scheme—and I would dispute that it's been warmly welcome by all paramedics, because I certainly have people who have a different view—is if a paramedic sees a patient and it is not appropriate for that patient to be transported in an ambulance because, clinically that's not appropriate, why is it then appropriate to use ambulance resources to pay for what is, essentially, either a social problem or a transport problem? Now, I appreciate, when faced with that situation and a person needs to go to hospital, they want to be helpful and they want to find some way of getting that patient to hospital, but I'm concerned that, if you do not clinically require an ambulance to get you to hospital, is the fact that the ambulance trust is relying on taxis to do that a failure to make progress on the wider non-emergency patient transport issues? I can see that there is a need to transport people to hospital. I'm just concerned that we're using these precious resources on what is now supposedly a clinical service to answer what is, essentially, probably, a social problem, in the fact that those people can't get to hospital any other way. That's what I'm concerned about.

[207] **Vaughan Gething:** In this instance, it's where somebody's responded to a call, and so the emergency vehicle is there. The difficulty is, when you have that person arriving and the paramedic crews arriving, do you then say, 'We're leaving. Get yourself to hospital'? I think that we'd have very difficult challenges if that was the response, or having a different form, if there's a need for that person to get to a hospital? If you say, 'That's always up to you', then why have any form of patient transport services at all? So, there are challenges about what we do and how generous we are, and what the expectation is and how we meet that expectation. I think they're fair questions to ask, but I think this pilot will tell us more about what the relative costs are and what the relative benefits are to the ambulance trust in terms of getting those vehicles available for a call that is appropriate for them to deal with, and also for the patient. There is not necessarily an easy or a simple answer.

[208] **Kirsty Williams:** So, are we in danger of creating an expectation that, if I ring 999, and I don't need to go to hospital in the ambulance—and they will come and tell me that—but the ambulance service will come, then book me a taxi and pay for that taxi in a way that, perhaps, before this scheme, I might have said to a relative or even myself, 'I'll pay for the taxi'? Are we creating an expectation that, if you ring 999, you'll end up with the ambulance trust paying for you, via taxi, to go to the Heath?

[209] **David Rees:** Can I ask a question? I want to expand upon that. When is the pilot due to end, so when will the evaluation take place? When can the questions that have just been asked actually be evaluated?

[210] **Vaughan Gething:** If I deal with the point Kirsty raised then, perhaps Dr Goodall can come back about the pilot.

[211] **Kirsty Williams:** That's what people can expect now.

[212] **Vaughan Gething:** No, I don't think so, because there are different messages around the use of the emergency service in any event: when you go through and ring that emergency service, the information you give, how that call is handled and the decision making at that end. This is part of the point about the overall performance, so are we conveying too many people to hospital under 999 conditions in any event? What do we do about the decision making by the call handler and the implementation of the clinical desk, because that should be a useful gap in terms of asking, 'Does this person really need a 999 response or a different response?' So, you'll just prevent people going in the first place to inappropriate calls. I think, if you're really worried about people having the mindset of, 'I can go to hospital and not have to pay for it if I simply go through this route', well, there's a very difficult mindset there in the first place about how people are prepared to misuse resources if you start with that point of view. That's why our Choose Well messages are important, in understanding what the appropriate treatment is for you, what's the appropriate use of this significant public resource, and the significant resource involved in an emergency ambulance service vehicle in any event. There's a difficult question about patient transport services and our own expectations about what we provide. Now, I don't think this scheme helps to create that unrealistic expectation that you can misuse the 999 service because this pilot exists. It's really about what happens when you've gone through all of the decision making, from a call being made to a call handler, to somebody arriving. What do you do at that point? I mean, you can get the emergency response vehicle—that precious resource—back into circulation as quickly as possible.

[213] **Kirsty Williams:** I understand that.

[214] **Dr Goodall:** [*Inaudible*.]—and it's an opportunity for us to focus on the demand that's coming into the service, with the very significant numbers coming in. As the Minister was saying, it is right that our conveyancing rates are too high at this stage. We have patients who'll be transported into A&Es across Wales, and a large proportion of them will simply be able to be discharged from the department, irrespective of having come in by an ambulance in the first place. So, I do think that we need to use that opportunity. Just to give some reassurance, it's not an automatic default that that would be called by a paramedic. They do make judgments at the time. One piece of feedback that we've had in these early stages is that it's at least allowed a discussion at the scene for people to talk—[*Inaudible.*]—and it's a check back with the family arrangements or whoever's around at the time to ensure that people can go in. The numbers are actually pretty small in the context of 500,000 calls in total, which shows, I think, that there's a judgment being made by the paramedics at the scene about not trying to have an abuse of this particular system. This has just been a default, really, that can be used, should there be a worry on the ground.

[215] From a timetable perspective, it's been an early pilot that has taken place, and actually, we have started to assure the ambulance service trust that this can just start to be stretched out across Wales to have some learning experience, but I would emphasise as well that that's along with a whole range of other actions and activities that are in place, so this is not the only answer—but I do think it will broker a broader discussion about use of ambulances and our ability to influence it.

[216] **David Rees:** I have one last question on ambulances and then I want to move on. Alun.

[217] **Alun Davies:** Yes, thank you. I'm interested in this whole subject of how we plan the delivery of services, and particularly out-patient services and patient transport. It's been put to me that, in some parts of my constituency for example, it takes two buses to get to Ysbyty Aneurin Bevan, but only one to get down to Nevill Hall. Therefore, although we're bringing the services closer to people, because perhaps of the location of the hospital or dislocation

with transport networks, we're actually making it somewhat more difficult for people to access those services.

[218] I've discussed in a different lifetime with Dr Goodall the creation of a critical care centre in Llanfrechfa Grange, which we're all very excited about and are looking forward to. However, the question that I have is about how we plan the delivery of those services for a community, which is a much wider and larger community than perhaps previously, and how people will be able to access both the services that they will require, possibly, potentially, as out-patients, but also how they will be able to access that facility as visitors. You know, I still remember canvassing in 2007, talking to somebody, in Devil's Bridge, who was desperately upset, because their partner was in hospital in Bronglais, and the buses meant they couldn't visit them. You know, issues like that, I think, are hugely important for how we deliver services.

11:00

[219] **David Rees:** Not a question on ambulances, but I'll let it go, and we'll come back.

[220] **Alun Davies:** It's on patient transport.

[221] **Mark Drakeford:** I think it's a complex question. It does link to the question Kirsty was asking about public expectation, and what a public service can legitimately be expected to provide, particularly in an age of austerity, and thinking ahead. We're very clear that, if you need an emergency medical response, the ambulance service is the right service to provide that, and we need to free up the ambulance service to concentrate on that. But we do have a relatively generous approach in Wales to patient transport. We take people to hospital appointments, out-patient appointments, paid for by the public purse, which, in other parts of the country, would not be paid for in that way: people would be expected to make their own way there. We do it, partly, in response to the fact that we have an older, sicker, poorer population, than in other parts of the country, but that cannot be an infinite extension of the public purse—paying for journeys that people might be able to make for themselves.

[222] Part of the answer to the wider question that Alun raised is: we take too many people to out-patients. We have far too many routine follow-ups that provide very little clinical value, where that conversation with the patient, if it is needed, could be held, for example, just as easily over the telephone as actually expecting the person to travel physically long and difficult distances for a 10-minute consultation to be told, 'Everything is fine, just carry on'. So, I am, personally, very interested in a fresh look at the way our out-patient system operates, altogether, to make sure that a follow-up appointment with a consultant as an out-patient should be a pretty precious resource, and not one that's used simply in a handle-turning way, where that service could be provided better.

[223] We definitely need to align our public transport more sensibly with our public services. Edwina Hart, as the transport Minister, has been pretty generous in giving both some expert staff time and some money to the health portfolio to allow us to do just that. We've got a number of changes to public transport arrangements, in parts of Wales, that are now doing exactly what the person in Devil's Bridge would have hoped: making sure that bus timetables and bus journeys are much better-aligned with major public service points that people need to get back and forth to. But, it is—you know, in a cliché—it's a whole-system thing you have to look at, and look at the way that different parts of public expenditure act together to the benefit of the citizen.

[224] **David Rees:** Thank you, Minister. Lynne, we'll come back to you now and then move on to Lindsay.

[225] **Lynne Neagle:** Yes, on social services. The Minister's report refers to the consultation that's just been completed on the tranche 1 of the regulations, codes et cetera. I just wanted to ask if there are any themes emerging from those consultations that you'd like to share with the committee.

[226] **Mark Drakeford:** Well, thanks, Lynne, for that. Absolutely right. We are consulting on the regulations, codes of practice and statutory guidance in two major tranches under the Act. The first major tranche consultation closed in February. I'm glad to be able to say that we are on track to publish the version of the regulations that we will put to the National Assembly in May, and it will then go through the different processes, depending on whether it's affirmative, superaffirmative and so on, here. It was a very good response to consultation; we had a very rich response. Some organisations, the Welsh Local Government Association, the Association of Directors of Social Services, for example, commented on all the regulations, and, then, third sector organisations, by and large, focused on those aspects that are of particular interest to the groups that they represent. We will definitely make changes, as a result of the consultation process. There are some ways in which we can simplify some of the things that we were consulting on. There is a theme of consistency—making sure that what we say in one part of the advice or the regulations is consistent with what we say in other parts—and we're taking steps make sure we amend some of our regulations to ensure that. And there's a theme of clarity, particularly in relation to the guidance. There was often a wish for us to be slightly more precise in the advice we were giving, to give some more practical examples of how the new system would work in practice. So, there's quite a job of work going on to make sure that we feed all of that into the regulations, which you then will see, and there'll be a further opportunity as part of the Assembly's procedures to scrutinise those and see if there's further improvement that can be made.

[227] We hope to bring tranche 1 of the results in front of the Assembly in June of this year, at about the same time that we will go out to consultation on tranche 2. Tranche 2 will end up back in front of the Assembly in November of this year, at which point the codes of practice and the statutory guidance will come together, because they will cover items that were in tranche 1 and tranche 2 of consultation. As those of you who were involved in scrutinising the 2014 Act will know, it is a framework Act with a lot of detail to be filled in through the regulations, codes and guidance. So, there's a large exercise involved here. I'm very grateful to those organisations that have taken part so far, and I'm looking forward to the opportunity to discuss it with Assembly Members as part of the scrutiny process and bring the Act fully onto the statute book.

[228] **Lynne Neagle:** Thanks, Mark. As you know, some of the children's organisations had misgivings about the sort of person-centred focus of the Bill. I just wanted to ask: has there been good engagement from children's organisations? Do you feel that, in the way that they've engaged, those concerns are being addressed? And I also wanted to ask about the exercise that's run in parallel with this, around preparing local authorities for the implementation of the Act. Are you confident that that work is reaping dividends? Also, how confident are you that the financial pressures facing local authorities isn't going to provide too much of a barrier to the implementation?

[229] **David Rees:** If I could ask for brief answers, Minister.

[230] **Mark Drakeford:** I'll do my best. Albert may have something to add. On the children's front, I think we do have to keep making the argument with some of our children's organisations that this is a people's Act. It is designed to help us to overcome some of the things that you'll be very familiar with of transition points, where suddenly someone stops being a child and becomes an adult and the whole system appears to be taken by surprise that this has happened. But what we are doing, as you know, is to gradually move in that direction. So, in safeguarding, we will continue to have separate safeguarding panels for children and for

adults, with an ambition, when we think the time is right, to move to single safeguarding systems.

[231] In terms of preparation, I'm encouraged by what is going on in terms of the regional partnerships. We have senior political and professional leaders engaged in it. We have citizens' panels as part of that in all parts of Wales. Gwenda Thomas, as part of her job as chair of the National Partnership Forum for Older People in Wales, I know intends to visit every regional partnership over the next couple of months to make sure that everything is in place. The self-assessment exercise of each regional partnership has been completed, which is broadly encouraging, with some areas that still need to be worked on. We've provided a transitional grant to local authorities; I was able to announce two weeks ago that we're doubling that next year—it's going to be £3 million next year, and hopefully £3 million the year after and then in to the revenue support grant, to be able to support the changes over the long term.

[232] This is a major Act, and we will have to see its implementation as a process over time rather than thinking that everything will be there on 6 April 2016. But I'm broadly encouraged by the preparation that local authorities have already undertaken to put themselves in the right position for the responsibilities they will inherit on that day.

[233] **David Rees:** Lindsay.

[234] **Lindsay Whittle:** Thank you, Chair. I wanted to talk about preventative care, if I could. I recently visited the northern resource centre at the top of the Rhymney valley, and it's an excellent multi-agency facility. Social services do an amazing job with early intervention for children and young people. I have an issue with Aneurin Bevan Local Health Board with a surgery in the lower Rhymney valley, which is, quite frankly, falling down—check my Facebook for not very good pictures of it—but I have a meeting with Aneurin Bevan tomorrow. My question is: when can we start to see a roll-out of facilities like the northern resource centre, which I have nothing but praise for?

[235] **Mark Drakeford:** I might ask other colleagues to help with some of the detail, but thanks to Lindsay for what he said about the Rhymney valley centre. I've been there too, and it's a very impressive place when you go there. One of the things that it does is to bring under the one roof all the sort of key players who provide those preventative and primary care services in the area. It was very interesting talking to people about their feeling about how more effective they can be when they're able to just walk across the room and talk to somebody else who's equally involved in the care of that family, or aspects of it. We have to do more on the preventative agenda; that's what the social services Act is all about. It's about moving the dial so that we help people to go on managing for longer, taking charge of their own lives in the way that we would like for ourselves, and they want for themselves, so that the aim of our public services is not to create dependency on them for the long run, but, actually, to put themselves out of a job as quickly as possible by just putting people back in a position where they can continue to do as much as they are able to do for themselves.

[236] That is equally true in the field of health. I make lots of speeches in conferences where I say that the future for the health service will be assured if we are able to make sure that, in future, we avoid those harms that are avoidable. So much of what the health service does today is dealing with harms that need never have happened. If people had acted differently in their own lives, in a more preventative way, in the way that the Caerphilly cohort study is probably the most dramatic example of, where people take those preventative steps in their own lives, their own health is preserved and better, and as a result, the health service doesn't end up having to attend to things that need not have happened in that way. But we have to do more. Government's responsibility is to create the conditions in which that is able to happen. The northern Rhymney valley centre is a very good example of that. We do

have plans in other parts of Wales to be doing more of it. We are really constrained by cuts in capital budgets available to us. We need a new model in primary care particularly. We can't go on with the old model, in which the public purse picked up the costs of what then became privately owned facilities.

[237] We're having some interesting conversations—but they are only conversations at this stage, I should stress—with organisations like the European Investment Bank, about whether an all-Wales approach to the primary care estate might allow us to lever in sources of funding that we've not been able to use in the past. So, there is a lot to do and I'm not for a minute claiming that we are close to having lots of very practical solutions, but you're absolutely right to point to the problem and we are interested in innovative ways of addressing it in the future.

[238] **Dr Goodall:** There are good experiences now to share, which are through different templates: if you look at the Builth Wells example and what that's giving us, and the Port Talbot resource centre that's in place, and over in Hywel Dda, there are different examples emerging. So, I think we can promote this more generally. Certainly, what we do have is an opportunity to work through some of the choices around sources of funding. So, we're very interested, for example, in the approach that was taken in the community campus at Blaenavon, which had stimulated a new practice being built up there. So, I do think, as the Minister said, we have some options. Of course, we do have to look at our capital portfolio, but at the same time, I think there are some different relationships we can assume.

[239] **David Rees:** I think we've got the gist of that one. I have three individuals who want to ask questions on this general section and then we'll move into financial. So, Kirsty, Darren and then Elin.

[240] **Kirsty Williams:** Thank you. Could I ask about performance with regard to referral-to-treatment times and also diagnostic waiting times? In January, just under a third of patients were still waiting over eight weeks for a diagnostic test. Could you outline when you feel that all patients will receive diagnostic tests within the Government's eight-week target? And could you give us an update, please, on performance with regard to ensuring that nobody waits over 26 weeks for treatment?

[241] **Vaughan Gething:** Performance is a regular part of my job and I have regular conversations with health boards about where they are. The average wait is still about 10 or 11 weeks, and that's a standard rate that people can expect. We recognise that too many people wait too long, and it's a conversation I've had with each health board about their 36-week figures in particular.

11:15

[242] It's really disappointing and we've made it very clear that the current rate of achievement is not where it should be, and they can't expect us to just airbrush over that, and so we won't. There are a number of particular specialities, so, for example, we regularly talk about ophthalmology, which is a really good example of where managing their lists in a different way will mean that people that need to get to be seen in a consultant setting will get that, and it will improve our performance by making better use of primary care. The—

[243] **Kirsty Williams:** There are almost 5,000 on those ophthalmology waiting lists, and you say there will be no people on those ophthalmology waiting lists.

[244] **Vaughan Gething:** Well, I've been remarkably clear with health boards about where they need to be. It goes back to this point in the earlier discussion about out-patients, and about how we design a system and what we expect of it, that, 'Just keep on doing what we're

doing at the moment' doesn't get us over the line, not in terms of figures, but in terms of what that means for the individual patient at the centre of that. It's the point that we've made and re-made about the need to look at having a different model of care and a different pathway. So, in Betsi Cadwaladr, they've looked at the list and they've taken people out who either don't need to be there at all, or could just as easily and safely be seen in primary care, and that accounts for about a third of the people on that list. So, people that do need to be on that list to see a consultant have a much better prospect of being seen, and seen within time. There's also interesting work going on in a number of other health boards about making better use of primary care, and that also means people get to be seen locally. Again, it goes back to the point made earlier about having to spend a long time going to hospital, all the travel, the parking, and having a short appointment. So, I recognise the point that's being made, and it is absolutely an issue that we're not letting up on.

[245] When we look at the intermediate plans—and we'll talk about it in the finance part—part of that is about ensuring that they plan to achieve performance, and it can't just be about having promises that, 'This will all be achieved in the final quarter of the year', because I don't think that's a very safe or sensible way to plan, and I wouldn't believe that that would happen if those were the promises that would be made. On diagnostics, we've seen some improvement from where we were, but, again, only 70 per cent of people are being seen within time, so the great majority are, but, again, we recognise that it isn't good enough. The money we've put in to deal with diagnostics has made a difference, and I expect to see further improvements to the end of the year. We will still be left with a number of people who'll be waiting over the target time. So, I recognise perfectly well the challenges that exist. Despite the improvements that have been made on diagnostics, I expect to see further improvement, and also, when we get the end-of-year figure for those people that have not been seen within time, there'll be a conversation around what has to then happen over the next year, and there'll be more conversation with both Assembly Members and health boards about what we expect from an accountability point of view to dealing with performance in the year ahead. I won't try and soft-soap it and say, 'Things are where they should be'. Even though the great majority of people are seen within time, our point is we want to see an improvement on where we are, and actually a much better prospect of achieving what all of us would expect the service to deliver.

[246] **David Rees:** Just for clarification, Deputy Minister, you talk about end of year, you're talking about end-of-financial-year figures.

[247] **Vaughan Gething:** Yes, end of financial year.

[248] **David Rees:** Just for the public to be aware. Do you want to come back?

[249] **Kirsty Williams:** Obviously, improvement is what we all want to see. It would be a pretty strange health Minister, or deputy health Minister, who expected the situation to get worse, and I'm sure they're quaking in their boots about the conversations you've been having with them. So the issue is, for me, the Government has quite clearly stated that you expect nobody to breach the ophthalmology 36-weeks wait, you expect everybody to have a diagnostic test within eight weeks, and you expect everybody to be treated within 26 weeks on the referral-to-treatment times, and I'm asking you: having studied this, having had all those conversations, when do you anticipate that local health boards will be able to deliver against your expectations?

[250] **Vaughan Gething:** I expect to see further improvement. I don't want to give a time that is, if you like, plucked from the air about where we'll get, but I expect to see 36-week breaches come down, I expect to see those 36-week breaches reduced progressively over the course of the next year, and I expect to see those planned for. What I don't want is that somebody comes up with an unrealistic profile and they haven't properly thought about how

they do that. In the past, I think some health boards haven't properly planned for that, and there's a recognition that planning is maturing, but that it's not perfect, and, again, I won't try and tell you otherwise. So, I expect to see further improvement over this next year on both the 26-week performance measure but equally the 36-week, and having zero breaches of that. In a number of areas we've seen progress on that. My frustration is that we don't see that delivered in a consistent enough manner, and in terms of collegiate and collective responsibility across the service, because this is about health boards working together across their boundaries, and, again, I think health board chairs like coming to see me—. They don't always enjoy the conversation, but the point is not about whether they enjoy coming to see me, the point is whether the health board is doing its job and whether the patient at the centre of all of this is getting the outcome they deserve. This also does go back to our conversation about targets and intelligent ones, because the time doesn't always tell us everything we should know about the patient experience and the patient outcome. They're often different things, in terms of the experience of going into the service and how you're treated and dealt with, not just a clinical outcome. So, I want to be able to say more to Members and to the public about the patient experience and patient outcomes when you look at the outcomes framework, which we'll be publishing over the next year.

[251] **Kirsty Williams:** Thank you.

[252] **David Rees:** Elin.

[253] **Elin Jones:** Diolch, Weinidog a Dirprwy Weinidog. Tri maes, yn gyflym: yn gyntaf, llawdriniaeth *cardiac* yn y de. Mae'r cyngor arbenigol i chi yn dweud y dylai unrhyw un sy'n disgwyl am lawdriniaeth *cardiac* gael y llawdriniaeth hynny o fewn 10 wythnos. Mae'r data mwyaf diweddar yn dangos fod 58 o'r 165 claf sy'n disgwyl llawdriniaeth yn Nhreforus yn aros dros 26 wythnos, a 31 o'r rheini dros 36 wythnos, ac mae hynny'n sylweddol yn uwch ac yn hirach na'r cyngor arbenigol i chi. Rwy'n ymwybodol o etholwyr, er enghraifft, sydd ar hyn o bryd yn aros o wythnos i wythnos gyda gohirio llawdriniaeth o Dreforus, a gofid sylweddol o gwmpas yr oedi hynny. Nawr, mae'ch adroddiad chi yn dweud fod yna welliant yng Nghaerdydd a'ch bod nawr yn edrych i gael cytundeb rhwng Caerdydd a Threforus i sicrhau bod Caerdydd yn cyflenwi dros Dreforus. A allwch chi roi sicrwydd i fi fod yna flaenoriaeth deilwng yn mynd i gael ei roi i'r bobl hynny sy'n aros am lawdriniaeth cardiac yn Nhreforus i gael y llawdriniaeth hynny yng Nghaerdydd os ydynt wedi bod yn aros tu hwnt i 26 wythnos? Cwestiwn wedyn ar—

Elin Jones: Thank you, Minister and Deputy Minister. There are three areas that I briefly want to touch upon: first of all, cardiac surgery in south Wales. Your expert advice states that anyone awaiting cardiac surgery should be receiving that surgery within 10 weeks. The most recent data demonstrate that 58 of the 165 patients awaiting surgery in Morriston are waiting over 26 weeks, and 31 of those are waiting longer than 36 weeks, and that is significantly longer than the expert advice that you've received. I'm aware of constituents, for example, who are waiting on a week-to-week basis seeing their surgery deferred in Morriston, and there is significant anxiety because of that. Now, your report states that there has been an improvement in Cardiff and that you are now looking for some sort of agreement or arrangement between Cardiff and Morriston to ensure that Cardiff provides on behalf of Morriston. Can you give me an assurance that sufficient priority will be given to those people who are awaiting cardiac surgery in Morriston so that they do get that treatment in Cardiff if they have been waiting beyond 26 weeks? Then a question—

[254] **David Rees:** Do that one first. I'll come back to you.

[255] **Elin Jones:** I'll just do them quickly.

[256] **David Rees:** Okay.

[257] **Elin Jones:** Cwestiwn wedyn ar feddyginiaethau newydd ac *access* i feddyginiaethau newydd. Byddwch yn gwybod bod y pwyllgor yma â diddordeb mawr yn y maes hwn, o ran defnydd y *exceptionality criteria*, ond yn benodol iawn ar yr hyn rydych chi a'r Prif Weinidog wedi bod yn dweud yn y Cynulliad llawn ynglŷn â'r anghysondeb rhwng byrddau iechyd yng Nghymru, a'r panelau a phenderfyniadau gwahanol y panelau, a allwch ein diweddaru ni, felly, ar sut rydych chi yn mynd i wella cysondeb o fewn Cymru, yn y man cyntaf, ac o bosib edrych i newid y gyfundrefn gyda phanelau lleol ym mhob bwrdd iechyd?

Elin Jones: Then a question on access to new medicines. You will know that this committee is particularly interested in this area, in terms of the exceptionality criteria, but very specifically on what you and the First Minister have been saying in Plenary on the inconsistency between health boards in Wales and the panels and the different decisions taken by those panels, can you give us an update, therefore, on how you are going to enhance consistency within Wales, initially, and possibly look at changing the regime with local panels in each and every health board?

[258] Yn olaf, wedyn, ar record electronig y claf—*electronic patient record*—rwy'n credu bod gyda chi uchelgais i weld hynny yn cael ei wireddu yng Nghymru. A allwch chi roi rhyw fath o amserlen inni o ran pryd rydych chi'n credu y bydd gan bob claf yng Nghymru yr *electronic patient record* yna, ac felly nid oes ots ym mhle mae'r claf hynny yn cysylltu â'r NHS, bydd yna wybodaeth ar gael o fewn yr NHS ar bob claf unigol.

Finally, on electronic patient records, I believe that you have an ambition to see that being delivered in Wales. Can you give us some sort of timetable on when you believe every patient in Wales will have that electronic patient record, and therefore it wouldn't matter where that patient actually contacted the NHS, information would be available within the NHS on each individual patient?

[259] **David Rees:** Minister.

[260] **Mark Drakeford:** Rwy'n mynd i ofyn i Vaughan i ddechrau, ar *gardiac*, rwy'n mynd i ateb y cwestiwn am gyffuriau newydd, ac rwy'n mynd i droi at Dr Goodall i ddweud rhywbeth ar yr amserlen am yr *electronic patient record.*

Mark Drakeford: I'll ask Vaughan to start on cardiac surgery, I'll take the question on new drugs, and I'll ask Dr Goodall to cover the issue of the timetable for the electronic patient record.

[261] **David Rees:** We'll start with the Deputy Minister on cardiac.

[262] **Vaughan Gething:** Okay, thank you, Mark, and thank you for the questions, Elin. I think, on the cardiac, I'll make a few comments. Dr Hussey, do you want to deal with the differentiated pathway question on 10 weeks?

[263] **Dr Hussey:** Yes.

[264] **Vaughan Gething:** Okay, because there's a point here about the 10-week target, if you like, the 10-week suggestion, and what that means. Because we're looking at different parts of the pathway, and that refers to part of the pathway, not the whole of it—not the whole, if you like, referral-to-treatment time. But, on cardiac surgery, I think there's a significant improvement story here. In 2013, the Royal College of Surgeons had significant concerns about what was happening; they now don't need to be kept informed what's happening. They're very pleased that Cardiff in particular has improved its service, not just in terms of dealing with the backlog, but in terms of outcomes as well. So, people are being seen more quickly, within time, and their outcomes from that treatment are impressive. So, there's been real progress over that last two years, and Abertawe Bro Morgannwg University Local Health

Board, and Morriston, in particular, had a bigger problem in terms of the backlog that it's had. And, again, there's been significant progress over the last year in reducing that backlog. Our understanding now is that there are only two people waiting over 36 weeks in Cardiff and Cardiff now has capacity so that the outsourcing of patients from outside the NHS in Wales has now stopped. So, that's really significant progress and it's really good news for patients in terms of more local care, but, as I said, the outcomes are impressive as well.

[265] **Elin Jones:** Talking mainly about Morriston and those people in west Wales who entered the service via referral to Morriston, what is being put in place now to tackle the backlog of over 26 weeks and over 36 weeks in Morriston?

[266] **Vaughan Gething:** Well, the backlog is being reduced and it's been reduced progressively over the course of the last year. Oddly, I was in Morriston about a month ago and I had a meeting with the chair of the health board and a range of people delivering this service, and I think the prospects for continued improvement are really positive. There's going to be some investment—

[267] **Elin Jones:** I don't want to hear about your meetings with chairs of health boards, I want to know—

[268] **Vaughan Gething:** But I'm telling you—

[269] **Elin Jones:** —what the pathway is and what confidence you have that Cardiff, as your report says, is now going to be taking on referrals from Morriston that aren't able to be treated because the capacity is still isn't up to speed to deal with the patients referred into the Morriston cardiac surgery.

[270] **Vaughan Gething:** That's the point about when I was there, about the conversation with clinicians about what they are able to do. That improvement I expect to continue and I expect there is going to be adequate capacity in Cardiff to help to further reduce that backlog to get to the position where all of us would want to be—where people are seen within target time and where clinical outcomes continue to improve. So, I'm positive about the fact that that will continue to improve and Cardiff will play its part. This is, again, the point about the whole system being joined up right across south Wales.

[271] The point you make about 10 weeks I think does deserve some explanation and attention, because it's about different parts of the pathway—

[272] **David Rees:** We do need to move on because of the time.

[273] **Vaughan Gething:** It's a question that's been asked and I wouldn't want to just ignore it and avoid it.

[274] **David Rees:** Short answer.

[275] **Dr Hussey:** I'll be brief. I think, with the opportunity to break down the pathway into the component parts of the diagnostic-to-treatment stages that people go through, what they're starting to uncover is where the pressure points are, and therefore you know which parts of the service need strengthening. So, it's a way of trying to very proactively manage the different elements that need to come together to make sure the pathway is shorter. The work is under way now and they're starting to get a better sense of what it is they need to put in place to keep the pace up on that pathway. It's a way of trying to be more focused and targeted in what needs to happen.

[276] **David Rees:** Just to back up the question on Morriston, you've said that you expect to

see progress being made, working with Cardiff. If that progress is not made, will you therefore reinitiate the out-of-Wales service to ensure that lists come down? It's a simple 'yes' or 'no'.

[277] **Vaughan Gething:** We'll have to look at where we are, but we want to make sure that—[*Inaudible*.]—and, obviously, in the past we have outsourced people. We need to make sure that, where they're outsourced, they do not just meet the demand, but also the outcomes are appropriate as well.

[278] **David Rees:** Minister, the question from—

[279] **Mark Drakeford:** Pan ydym yn siarad am gyffuriau newydd, y peth gorau i'w wneud, wrth gwrs, yw mynd trwy NICE a'r AWMSG. Pan ydyn nhw'n dweud bod cyffur newydd yn effeithiol, mae e'n ar gael ym mhob man yng Nghymru. Mae rhai cyffuriau sydd ddim wedi llwyddo i fynd trwy'r broses yna, ond mae clinigwyr yn meddwl ei bod yn bosib y bydd cyffur newydd yn effeithiol mewn achos unigolyn, ac maen nhw'n mynd trwy'r IPFR *process*. Ar y cyfan, mae'r broses yn gweithio, rwy'n meddwl, ond rydym ni'n gallu cryfhau'r broses i fod yn glir gyda phobl fod y broses yn deg ac yn gyfartal, ac nad oes—fel roedd Elin yn dweud—anghysondeb rhwng beth sy'n digwydd mewn un panel a phanel rhywle arall yng Nghymru. So, y ffordd orau i wneud hynny yw—. Rydym ni wedi ariannu yr AWTTC i helpu, ac yn y dyfodol byddwn ni'n defnyddio mwy o beth maen nhw'n ei alw yn Saesneg yn *cohort decisions*. Pan fyddan nhw'n gweld yr un achos yn dod ymlaen ledled Cymru, bydd yr AWTTC yn gwneud y penderfyniad ac yn tynnu hwnnw mas o'r IPFR *process* i gyd.

Mark Drakeford: When we're discussing new drugs, the best thing to do, of course, is to go through NICE and the AWMSG. When they say that a new drug is effective, it is available in all parts of Wales. There are certain drugs that haven't succeeded in that process, but clinicians believe it's possible that a new drug will be effective in an individual case, and then they go through the IPFR process. Generally speaking, the process works, I think, but we can make the process more robust to be clear with people that the process is fair and equitable, and there isn't—as Elin said—inconsistency between what happens in one panel and another in different parts of Wales. So, the best way of achieving that—. We have funded the AWTTC to assist, and in future we will be using more of what they call in English 'cohort decisions'. When they see the same case coming forward across Wales, the AWTTC will make the decision and take that out of the whole IPFR process.

[280] Nid yw'n dderbyniol i fi ein bod yn gallu gweld achosion, fel roedd Kirsty a Lynne wedi codi, ble mae unigolion yn gallu gweld eu bod yn mynd i gael penderfyniad arall mewn bwrdd iechyd arall.

It's not acceptable to me that we can see cases, as Kirsty and Lynne mentioned, where individuals can see that a decision would be different in another health board.

11:30

[281] Rwyf wedi gofyn i Dr Goodall i fynd yn ôl at adroddiad y panel rŷm ni wedi ei sefydlu i weld a oes unrhyw beth arall rŷm ni'n gallu ei wneud. Mae rhai pobl yn awgrymu cael panel cenedlaethol, ond mae 740 o achosion bob blwyddyn yma yng Nghymru ac mae'r paneli'n gallu delio â phump neu chwech o achosion mewn un diwrnod. So, os ydym yn mynd i gael panel cenedlaethol, bydd hwnnw'n eistedd bron

I have asked Dr Goodall to return to the report by the panel that we established to see if there is anything else that we can do in this area. Some people have suggested that we should have a national panel, but there are 740 cases per annum here in Wales and the panels can deal with five or six cases in one day. So, if we're to have a national panel, then that panel would sit virtually every day. That simply isn't practical.

bob dydd. Nid yw hynny'n ymarferol.

[282] Ond, a ydy e'n bosibl—rwy'n mynd i ofyn i Dr Goodall i ailfeddwl—er enghraifft, i gael paneli rhanbarthol, sy'n gwneud mwy i osgoi'r sefyllfa roedd Kirsty a Lynne yn codi o ran pobl sy'n byw yn eu hardaloedd nhw? So, rŷm ni ar y ffordd i wneud pethau'n well a jest i roi hyder i bobl yng Nghymru nad yw'r system yn dibynnu ar ble mae pobl yn byw o ran y penderfyniadau y mae'r system yn ei wneud.

But, is it possible—I will ask Dr Goodall to think, once again—for example, to have regional panels, which could do more to avoid the situation that both Kirsty and Lynne raised in terms of people who live in their constituencies? So, we are progressing and making improvements, and I just want to give people in Wales confidence that the system doesn't depend on where people live in terms of the decisions taken.

[283] Jest yn gyflym ar y trydydd peth, ar yr *electronic patient records*, mae Andrew yn gallu rhoi'r amserlen.

Just very briefly on that third issue of electronic patient records, I think Andrew can give you that timetable.

[284] **Dr Goodall:** We're taking a fresh look at our e-health strategy to build on the foundations that are there, not least with the Minister's own interest and his expectations during part of that particular process in Wales. We are bringing together a lot of different components to give us our electronic patient record for Wales. So, progress over this recent period has been—. We've made Myrddin our default patient management system for Wales and that actually started off in the Hywel Dda area. We've built on that across Wales with a roll-out plan that allows us to make sure that we can have systems that can talk to each other, not just across the local communities, because there have been variable systems in place, but across Wales. We've looked at our GP systems in Wales to ensure that they can talk to each other and to health boards, in different ways, and we've ended up with a process of two systems now being the main systems for use within the primary care sector.

[285] We've been rolling out our pathology systems for Wales through a national process to make pathology test results available to clinical staff as and when they require them. We've refreshed our radiology approach with our systems being rolled out across Wales that allow the images to be presented in clinics and actually to clinical staff very immediately. Also, we are hoping that we can make some progress around community and social care information systems for the future, to make sure that that is a fundamental enabler for the service in Wales to be taken forward. That's been reviewed over this recent period of time by a particular piece of work and a programme that's been taken forward. So, we have the individual component parts being built through. We need people to take advantage of the technology that's available, but I know we also need to be mindful that it's not just about systems as boxes hidden away in the back of areas. We've got to be flexible about the new and emerging uses of technology that are coming into the system as well.

[286] **Elin Jones:** So, are we likely to get to a point where each individual will have an electronic patient record and all your test results and scans and everything will be on that record and if you fall ill and happen to be in Cardiff on a particular day, even if you're from Aberystwyth, then a Cardiff A&E department will be able to see all of your details?

[287] **Dr Goodall:** That remains the aim.

[288] **Elin Jones:** Is that what you're aiming for?

[289] **Dr Goodall:** That is what we're aiming for in terms of allowing for that. The Minister announced recently that emergency department systems are going to be implemented right across Wales, which is to create that kind of consistency, so the systems can talk to each other. It's also important that it's not just about those emergency systems; they need to be able to

draw on the radiology tests and investigations and link over to primary care too.

[290] **Elin Jones:** When?

[291] **Dr Goodall:** We're currently refreshing that through a review of the e-health strategy. Our intention will be to outline some of the timetables and expectations on that, but really building on the progress that's been made to date.

[292] **Mark Drakeford:** ABMU is the first health board to take the new emergency department electronic package. I'm very keen on that, particularly, because we know that patients from the Hywel Dda area will end up needing emergency care from time to time in the ABMU area. I want clinicians in ABMU to be able to have access as fast as possible to the most comprehensive set of information they can, so that they can make sure that they're getting the best treatment to patients. We're starting there.

[293] **David Rees:** We've already extended our general section, so Darren's is going to be the last question in this area and we do want to move on to financial then.

[294] **Darren Millar:** Minister, you know only too well that there's a significant amount of anger in north Wales at the moment over the way in which the Betsi Cadwaladr university health board went about making a decision on the future of its women's clinical services. We had a debate on this yesterday, so I won't go through the arguments that surround that decision, but I just want to focus on the decision-making processes within NHS Wales, if I can. You'll be aware that you have issued, obviously, guidance, or there is national guidance, on the need for public engagement and how decisions need to be made. How do you as a Government hold people's feet to the fire to ensure that they implement that guidance, and the spirit of that guidance, on the ground across Wales?

[295] **Mark Drakeford:** Well, Chair, just to say that I fully accept that there is a role for Government in making sure that, in this very difficult area, because none of us—. We all know, don't we, that trying to bring about change in the health service of any sort is very difficult, and public engagement is often fraught with people's anxieties about what change will mean for them? So, there is a real job for Government in making sure that we equip our health boards as well as they can be to carry out that—[*Inaudible*.]—that they learn the lessons from one another, and that we have systems to back that up through CHCs and others.

[296] You know that I asked Ann Lloyd to undertake a review of the changes that we'd had in the last round here in Wales. I thought her report was very useful to local health boards. We've required local health boards to consider her report at board level to make sure that, when they are next embarked on the process of change, they can learn from that report about what did work and what didn't work in different parts of Wales. Difficult as the process is, I've been heartened by the fact that the legal challenges that have been mounted against almost every change that we have seen in Wales have been tested through the courts, and on every single occasion, the judgment of the High Court has been that health boards and all of the other component parts, including a CHC that was challenged through judicial review, had discharged their responsibilities successfully within the lines of the guidance that we provide. We know it doesn't go well every time. We know that not everybody does it as well as we would like them to do, and I accept that we have a job, as Government, in trying to make sure that people are properly equipped and then discharge things in the way that we would like to see them discharged.

[297] **Darren Millar:** Can I ask you about engagement with staff who might be affected by the proposals? One thing that many people found extraordinary was that the staff who were directly going to be affected by these changes had not been consulted prior to them being brought to the board. There'd been no discussion with them whatsoever, nor any discussions,

frankly, with the trade union representative groups. It was simply a telephone call the day before, or, in the case of one trade union, on the day of the decision being made. Do you think that your guidance needs to be reviewed and needs to be more prescriptive about things like that, even when an urgent service change might become necessary?

[298] **Mark Drakeford:** I'm happy to take a look at our guidance to see whether it does encompass that sufficiently.

[299] **Darren Millar:** That's good.

[300] **Mark Drakeford:** What I'm sure is the case is that, when it's done well—and I think it was done well in the south Wales programme—then you get genuine clinical and staff buy-in to the process. It was a real strength of the south Wales programme that, when there were difficult meetings, and there certainly were difficult meetings, the public had a single voice from clinicians about the case for change, the need for change, and the range of proposals that were being put to them. [*Interruption.*] Well, any one of us as Assembly Members faced with change in our own constituencies would come under very significant pressure to represent the voices of people who are concerned about those changes, but where we have clinical consensus—and that clearly is created by involving staff in decisions—then at least the public get a chance to hear from their clinicians about what they, as the professional leaders in that area, think should happen. So, I'm agreeing with Darren's original proposition that making sure that those people are involved in decisions strengthens the whole process, particularly when they're prepared to coalesce around some quite difficult changes.

[301] The mid Wales review that we've had, and the hopes we have for what will flow from that, are also much strengthened by the fact that clinicians have been willing to come together around a set of ideas and potential models for the future, and that gives the public confidence in taking change that will be required.

[302] **Darren Millar:** And I'm pleased also that you've agreed to reflect on the guidance and its adequacy. I mean, obviously, the health board's trying to rescue the situation to some extent, in undertaking further engagement now that the decision is made, but obviously the horse has already bolted. Can I just ask you one final question? One of the significant bearers on this decision—significant factors that've been considered by the health board—has been the ratio of the use of locums within the department in question. Now, clearly, they have taken an arbitrary figure of no locum use over 50 per cent on that particular rota. Do you think that there needs to be more clarification from the Welsh Government on what it regards as safe or unsafe care for each individual clinical discipline across Wales, so that there can be some sort of guide? Because, clearly, there appears to be very little academic evidence to support the board's assertion that locum rates above a certain percentage might be putting patients at risk.

[303] **Mark Drakeford:** I might ask the chief medical officer whether she thinks national guidelines would be useful in that context. My own, sort of, lay starting point would be that these are likely to be very context-specific decisions. One of the real difficulties about the whole locum debate, Chair, is that we use a single term to describe at least three very different sets of circumstances. We have locums who are appointed to cover a substantial period of time—somebody's on study leave, maternity leave, whatever—and those are people who are on the books of the health board, directly employed by them, but are locums. We have internal locums—people who are employed by a health board in one capacity, but are willing to help out in a different part of the health board on a locum basis. Again, they are permanent parts of the health board establishment. And then we have what I think most people think we mean by locum, which is someone employed by an agency, who comes in for a day and may never be seen again. Now, the clinical care offered will be very different, or the risks involved will be very different if it's someone who's been there for months on a semi-permanent basis rather than if it's someone who doesn't know the set-up and may only be there for a short period of

time. But I'll ask—.

[304] **Darren Millar:** If I can just reflect on that before Dr Hussey comes in, I think that that was one of the concerns that Assembly Members in north Wales had about the assertion that things might be unsafe as a result of the locum use at Glan Clwyd Hospital. A number of those locums had been there for a number of years. They were clearly not in the more risky category of having received a phone call on the day and called in at short notice.

[305] **David Rees:** Point made. Ruth.

[306] **Dr Hussey:** Well, just very briefly. Look, the starting point for me is making sure that we have safe systems, and safe systems require well-trained individuals, working together in teams in a co-ordinated way, reflecting on their practice, monitoring the outcomes of their care and so on. So, what we're describing here is, when you can't maintain the ideal stable situation, how much risk are you prepared to take? I think it opens up lots of questions. The Minister's described some of the complexities of it, but also, what if you have locums at every grade level of a system, where there's nobody who's from the permanent team there? So, there's lots of different nuances on it. I think it's opening up a question for us to consider, but it's a complex one. My aim—the prime aim—is to have safe teams working together effectively, as members of those teams, well-trained and familiar with the circumstances and the systems in place in that organisation. That's got to be our focus. So, whilst I recognise there'll be situations where we have to have temporary arrangements in place, I think that we've really got to try and stabilise our services in a way that is sustainable.

[307] **Darren Millar:** But you agree to look at that issue of the use of locums, given the different types that the NHS might be engaged with.

[308] **Dr Hussey:** We can certainly discuss the clinical risks that pertain, and talk to our colleagues in the other health boards around how they manage these situations. We can have that conversation, but, as I say, the main focus is that we must have effective team working, staff who are trained in the systems in that organisation, and that's got to be our focus—to have sustainable services.

[309] **David Rees:** Okay, thank you for that. I'm conscious of the time. We've already spent more than we anticipated on the general, but I wanted Members to have the opportunity. Minister, will you be prepared to stay extra 10 minutes, so that we can get some financial aspects out of the way, and we'll finish at five to?

[310] **Mark Drakeford:** Yes.

[311] **David Rees:** Is that okay? So, we'll have a changeover.

11:45

[312] **Mark Drakeford:** So, we're joined by Martin Sollis, Chair, who is head of the finance part of my department.

[313] **David Rees:** Welcome. If we start off with Kirsty, followed by Darren then Jenny.

[314] **Kirsty Williams:** [*Inaudible.*]—allocation formulas for local health boards, but I'm concerned about how money flows throughout the NHS, especially, if I can be slightly parochial, in how commissioning services in Powys work and how money flows from Powys to neighbouring health boards, which I think gives us a very raw deal. I'm just wondering whether any work has being carried out to look at how money flows within the system, not just on allocations.

[315] **Mark Drakeford:** Chair, I'll be brief. Work is going on on that. It's a more urgent issue than it once was because of the three-alliances model of the south Wales programme, which means that, in the future, patients will move more freely across LHB boundaries. We've had—'ad hoc' would not be the right term to use here—a pragmatic approach to those costs in the past. I think we will need a more systematic approach to them. I'm anxious to avoid tariff systems if we can. I'm not keen to invent a whole industry of accountants around patient flows and costs that go with them, but it is certainly the case that we have to make sure that we have a fair allocation of costs and that that will become a more significant issue for all health boards in the future. So, work is going on, which Martin is leading. It's not concluded yet, but we are on that case.

[316] **David Rees:** Darren.

[317] **Darren Millar:** Can I just ask you, will the NHS break even this year?

[318] **Mark Drakeford:** Yes, Chair.

[319] **Darren Millar:** You're confident of that.

[320] **Mark Drakeford:** It's my responsibility to make sure that my departmental budget, which includes the NHS in Wales, lives within the money that has been voted to it by the National Assembly, and I'm confident that we will achieve that.

[321] **Darren Millar:** With its existing resources or an additional allocation?

[322] **Mark Drakeford:** Within the resources that have already been allocated to the NHS this year.

[323] **Darren Millar:** Does that mean that every individual health board will break even?

[324] **Mark Drakeford:** No.

[325] **Darren Millar:** Will some do so with brokerage?

[326] **Mark Drakeford:** At this point, Chair, I anticipate there will be three health boards that will not break even and that others will. That may involve a minor brokerage at that level, but there will be three organisations that, as I see the figures at the moment, I do not believe will live within the means that have been provided to them.

[327] **Darren Millar:** And which will those three boards be?

[328] **Mark Drakeford:** They will be Betsi Cadwaladr, Cardiff, and Hywel Dda.

[329] **Darren Millar:** In terms of Cardiff, that certainly has a three-year financial plan, doesn't it? So, why are things so wrong in year 1 of their three-year financial plan?

[330] **Mark Drakeford:** The Cardiff position is very disappointing, given that they had a three-year plan. There are some assumptions that they made in year 1 that they have not been able to deliver on. I am open to some of the arguments that Cardiff makes about the way that the current formula reflects the cost, as a tertiary centre, that it incurs. Cardiff LHB has the lowest cost per head—so, they are given by the formula the lowest amount per head—of any health board in Wales, despite the fact that it has the most densely urban population, the most ethnically diverse population and the University Hospital of Wales, which has a halo effect in terms of demand on tertiary services. I'm prepared to look at those things with Cardiff, but I

don't disguise my disappointment at the gap between where the health board had intended to be at the end of this financial year and where it appears it will end up.

[331] **Darren Millar:** Of course, there are challenges in rural settings as well to provide care over a rural and sparse population, if you like. It's not just about urban areas. Betsi Cadwaladr's challenges, perhaps, might reflect that. You've suggested that you want to shift across to the Townsend formula in the future, or a tweaked Townsend formula. Where are you in terms of the review of that at the moment?

[332] **Mark Drakeford:** Well, we've already implemented some aspects of the review in the way that we have allocated the £200 million additional funding for next year. The effect of moving towards Townsend is the same today as it was when we were in better times and were more able to differentially distribute the dividend of growth. So, in terms of the impact of that, with £200 million, and going in extra to the formula, the impact is relatively marginal, but Cwm Taf, as you would expect, is the biggest gainer, followed by Aneurin Bevan, Cardiff and ABMU, and there are some marginal—but they are very marginal—smaller shares of that growth than would otherwise have been the case for the other three health boards.

[333] **Darren Millar:** And, of course, Betsi Cadwaladr has given you a draft three-year plan. Can you tell me what that draft three-year plan includes in terms of allocations on the shape of its capital programme?

[334] **Mark Drakeford:** I might ask Martin to—

[335] **Darren Millar:** Sorry to be a bit parochial on that question.

[336] **Mark Drakeford:** Yes, sorry, I don't have the capital aspect of the plan in my head. We can write to you with the detail, if we don't.

[337] **Darren Millar:** That would be helpful. If I could just ask, perhaps, about a specific element, and that is, at Ysbyty Gwynedd, there was a project there on their emergency department, which has been in the pipeline for a long time, with significant delays. Is that in the three-year plan and, if so, roughly when will it be delivered?

[338] **Mr Sollis:** It's in the three-year plan. We've already committed expenditure to the next phase of work at YGC, so that is in there, and we've already committed, in terms of the capital programme—

[339] **Darren Millar:** For the current or the next financial year?

[340] **Mark Drakeford:** We'll make sure we give you the most accurate—I want to make sure we give it to you accurately.

[341] **Darren Millar:** Diolch yn fawr.

[342] **David Rees:** Jenny?

[343] **Jenny Rathbone:** In your report for us, you report some very positive things about the improved services at Withybush, where the midwife-led unit has exceeded expected usage—very positive outcomes—and neonatal services are now compliant with the all-Wales neonatal standards. Obviously, it'd be good to bottle that information and distribute it elsewhere. I want to know whether there are any figures, at this stage, as to whether this reconfigured service is also better value for money?

[344] **Mark Drakeford:** There are financial consequences of the remodelling of services

between Withybush and Glangwili, as far as those services are concerned. The service has been delivered within the financial envelope that was agreed by Welsh Government, but the service is a better service than was there before, because it meets the neonatal standards in a way that the previous service didn't over time, but not quite as well as we would like it to, at this moment. It will provide a better standard of parent accommodation, for example, at Glangwili, than has been available before. So, we are spending more on the service, in order to make sure that it's of the standard that we want it to be, but it's being delivered within the envelope that's been agreed with Welsh Government.

[345] **Jenny Rathbone:** So, at what point might it be possible to say that this reconfigured service is now, actually—. I appreciate these are complex things, because it's about outcomes.

[346] **Mark Drakeford:** I wouldn't anticipate it being available for at least another 12 months. Part of this change only happened in October of last year. The refurbished midwife-led service at Withybush was only opened by Vaughan a matter of weeks ago. So, we're still at the earlier part of being confident of where the costs have been driven and how much we're now paying for that service.

[347] **David Rees:** Just one final question: on the £40 million additional for winter pressures, you've identified in your paper £8 million has been allocated, and £32 million is being centrally held. Have you any idea what criteria will be used to actually identify how that will be allocated?

[348] **Mark Drakeford:** The remaining £32 million, Chair, will be allocated according to three main criteria. First of all, as a result of winter pressures, you'll be aware that some planned elective surgery has had to be postponed for some patients in parts of Wales. I want to use part of the £32 million to see whether any of that ground can be recovered in the final part of the financial year, in order to not delay treatment any further. So, some of the money will go on that. Secondly, I am aware from some health boards that they took on extra costs during the winter, in order to cope with the pressures that they were under, and, where they're able to identify those, I'm prepared to provide for those costs directly from the £32 million. Then, there have been other health boards where we've been able to ensure that decisions were not made over the winter period, which would have had an even more pronounced effect on planned services. I'm prepared to take that into account in the £32 million, but I may not be prepared to hand that money directly to health boards.

[349] **David Rees:** All right, Minister, time is catching us up and you've given us extra time, so thank you very much, and Deputy Minister, for your time. Can I also thank your officials for their time? You will receive a copy of the transcript, as usual, for any factual inaccuracies. Please let us know.

11:55

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 15
Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 15

[350] **David Rees:** Time is tight, so we'll move straight on, if Members are happy, to the next session, which is the final evidence session for the Safe Nurse Staffing Levels (Wales) Bill. I just remind Members that the final session is with the Welsh independent health body and Care Forum Wales.

[351] Can I welcome you to this session? Members have just popped out for a comfort break, I think, but we'll continue on, if that's okay, because we are quorate. They'll be popping back in. Just to let you be aware, the microphones will come on automatically. If

there's any requirement for Welsh translation simultaneously, the headphones are set up for channel 1 or if you need amplification, channel 2.

[352] Can I welcome, therefore, Anne Thomas, Linc Cymru and representing Care Forum Wales and Melanie Minty, who is also representing Care Forum Wales? We have Michele Millard, representing Spire Cardiff Hospital and the Welsh Independent Healthcare Association, and Simon Rogers, who is also representing the Welsh Independent Healthcare Association. Can I first of all thank you for your written evidence, which has been provided to the committee? Thank you for that. Clearly, it leads us on to some questions to expand on the impact that you believe there will be in relation to the safe nurse staffing Bill that has come before us and how it may affect your own sectors. So, Gwyn Price, do you want to start the questions?

[353] **Gwyn R. Price:** Could I ask Care Forum Wales to expand on their concerns that if the Bill does not apply to nursing homes, it will adversely affect them? Could you expand on your thoughts behind that?

[354] **Ms Minty:** Yes, certainly. It certainly wouldn't be a single cause of a shortage in care homes, but we're concerned that it would aggravate an existing situation. We're already seeing that care homes are either closing or deregulating and becoming residential homes because we're finding it very difficult to compete with the NHS for nurses. We're basically both fishing from the same small pool, and it's difficult for care homes to compete with the NHS because the rates at which we're commissioned by the NHS, we're not able to afford the same terms and conditions for nurses. Also, it's not seen by some nurses as being such an interesting career as a career in the NHS. You'll be more than aware of the media interest and the regular criticism that the care sector gets, so it doesn't encourage new people to join the sector. So, our concern is that if the NHS is going to be looking to create or bring in additional staff, in the first instance, that's going to come from the pool of nurses in the private sector.

[355] **Gwyn R. Price:** Do you have ratios at the moment in nursing homes with regard to patients?

[356] **Ms Minty:** Sorry—reassurance?

[357] **Gwyn R. Price:** Ratios.

[358] **Ms Minty:** Ratios—sorry. There are no formal ratios set out. Anne might be able to give you an example,

[359] **Ms Thomas:** Yes. In our homes, we have one nurse and four care assistants for every 15 people.

[360] **Gwyn R. Price:** Okay, thank you very much, Chair.

[361] **David Rees:** Lindsay.

[362] **Lindsay Whittle:** It's just a quick supplementary, Chair, and it's about the recruitment of nursing staff. I wonder whether you're experiencing any great difficulties. You touched briefly on finance, but if you needed more nursing staff and the nursing staff were ill, how would that affect your budgets, please?

[363] **Ms Minty:** At the moment, there is already a fairly severe shortage of nurses, and a lot of members are having to rely on agency nurses, which is where it begins, after a while, to become unviable financially. In terms of recruitment, the situation for the private sector is that we're not in control of that.

12:00

[364] All nurses have to go through degree nursing and they're all commissioned by the NHS. Although we've been talking to Government and getting assurances that the recruitment for the private sector is going to improve, that's obviously a long-term objective, because nursing degrees take three years. So it doesn't resolve the immediate concerns that we have for short-term nursing shortages. I believe, at the moment, certain health boards themselves are having to go abroad—to Spain and other places—to recruit nurses because there is such a small pool in Wales.

[365] **Lindsay Whittle:** Just a quick follow up, Chair. We've heard evidence from the main person who is putting the Bill that, in fact, some nurses may be encouraged to return. The nurses are there, but just not working in the field. They may be encouraged to return to nursing, because the improved ratio and the extra nurses would actually make their job just a little bit easier—I won't say easier, because it's a tough job, nursing, and we understand that.

[366] **Ms Minty:** I suppose it's something that could happen in the long term, but, again, you still go back to the difficulty in competing. The NHS are able to pay nurses much higher wages, sick pay, they offer them a better career structure—because there isn't much of a career structure unless you become a manager in a care home. I think what you could see is that, if we did get the nurses coming back from the NHS, we might get some of the people who don't really want to be working there but are pushed out or people who are coming up to the end of their careers or whatever. So, we wouldn't necessarily get the sort of premium-quality nurses that you need in care homes to look after our very vulnerable older people.

[367] **Lindsay Whittle:** Would flexible hours help?

[368] **Ms Minty:** I don't know. Can you answer that one, Anne?

[369] **Ms Thomas:** No, flexible hours isn't an issue when we recruit staff. The issue for us is having the right calibre of staff who genuinely want to work with older people. Because, as Melanie was saying, the training focuses on the needs of the NHS, it's not a career that's chosen by many at the outset. Historically, the workforce planning has assumed that nurses who fall out of the NHS will be sufficient to staff care homes, and that really isn't an acceptable position, given the nature of the frailty of the people we look after now.

[370] **Lindsay Whittle:** Okay. Thank you, Chair.

[371] **David Rees:** Lynne.

[372] **Lynne Neagle:** The Bill that we are considering takes a triangulated approach to staffing levels, which includes looking at acuity. Would you welcome measures to put more emphasis on the acuity of patients in care homes? For example, I've seen problems where, in care homes, although they may have the appropriate numbers, the staff there are not suitably qualified to deal with, say, somebody with dementia with challenging behaviour. So, is that something you'd welcome: more regulation in the care home sector to tackle those problems?

[373] **Ms Thomas:** I don't think regulation on its own will tackle those problems. I think there is a wider workforce issue about making sure that, right from the beginning, the recruitment and training of nurses isn't just centred around the NHS and that it acknowledges the amount of care that is given outside of an NHS setting. With that will come people who choose positively a career with older people, and that would follow through, then, to support people to have the right skills. And then you can regulate against that. But, I think, if we talk about regulation now, that's the end of a set of other processes that need to be put in place.

[374] **David Rees:** Darren.

[375] **Darren Millar:** You've made it clear, obviously, that you support—both organisations represented—the extension of the provisions in the Bill around safe nurse staffing levels within your sector. Lots of people will find that surprising, actually, but I think it shows that you're clearly very committed to wanting to deliver the best high-quality care that you possibly can. You make the link, of course, with wanting necessary resources to flow where the NHS commissions that care within your organisations, and it seems to me that it would be quite straightforward, really, for the committee to recommend, perhaps, to the Member in charge, that NHS-commissioned care should be clearly within the scope of the provisions in the Bill. What about privately funded care that is not NHS commissioned? Do you support the extension of the provisions of the Bill to privately funded care, completely?

[376] **Ms Thomas:** Yes.

[377] **Darren Millar:** You do. I mean, I suspect you're already more than meeting what would be considered to be safe staffing levels when it comes to privately funded care, aren't you?

[378] **Ms Millard:** I would agree that we are meeting the standards that are within the Bill in a general sense. But, what you have to understand is, of course, our structures may be somewhat different from the NHS within the nursing hierarchy. Therefore, there are elements of that we would have to explain, rather than it being a clear cut, 'Yes, we comply'. On the basis of ratios, I don't think there's any doubt that any of the independent sector's acute providers would meet the standards within this Bill.

[379] **Darren Millar:** Do you think, therefore, that it's a bit meaningless, actually, attaching any of this? If you're already meeting—. You know, for non-NHS commissioned care, if you're already meeting those standards, then why on earth have any sort of ratio requirement, anyway? Some people have argued completely against ratios and simply argued for guidance, which makes it clear in terms of the safety of nurse staffing, but given that you're already meeting them, why on earth would you want regulation to back it up?

[380] **Ms Millard:** Because, as a nurse myself, I believe in the protection of patients and that patients deserve the highest care, no matter where that care is being provided.

[381] **Darren Millar:** So, it's about a message to the profession and a message to patients, really, to give them confidence that they are both supported in the workplace and, indeed, if it's the place where they're being cared for.

[382] **Ms Millard:** Absolutely. Also, for these things to be measured, to be set within a Bill means there's a standard to meet and a standard to measure. I don't think it can be purely on number; I would agree with that wholeheartedly. There have to be other elements in there about the dependency of the patient and their care requirements. For that reason, as we stated in our reply, a lot of our standards are what we would call minimum standards. So, we will often have more nurses than that standard, but it will not fall below that standard.

[383] **Darren Millar:** There are some figures from Care Forum Wales on the number of nursing beds out there, which are pretty staggering, really, compared to the number of hospital beds. I think you exceed the number of hospital beds. What is the total number of beds within the independent hospital network in Wales?

[384] **Mr Rogers:** Within the acute sector, it's 223. There are 355 mental health beds and 73 learning disability beds.

[385] **Darren Millar:** So, you're significant providers.

[386] **Mr Rogers:** Yes, and that's just within WIHA.

[387] **Darren Millar:** All the support compared to the NHS is a significant proportion. So, just to be clear: you want to see the provisions of this Bill extended to your industry in order to support the nursing profession and give confidence to patients, but you need to see some resources attached, particularly when there's NHS commissioning.

[388] **Ms Millard:** And we would very much welcome the opportunity to be involved in workforce planning with this. We have, in the past, had some input into some of the educational groups and the forward planning for workforce, and we would very much like to continue with that.

[389] **Darren Millar:** One of the aspects of the Bill that you haven't commented on greatly in the written evidence that we've received, is how the Welsh Government will monitor compliance. The Bill is more of a framework Bill, really, in terms of how it seeks to address that. It basically says, 'We'll sort out the detail of that later', effectively—there are some components of details that would have to be reported back by health boards. But do you envisage any problem in providing the sort of data, given that you have different data collection systems et cetera from one group of care homes to the next and from one group of independent hospitals to the next? Do you envisage any problems in meeting the requirements of the Bill, as currently set out, in terms of providing information back to satisfy the—?

[390] **Mr Rogers:** I think it would be helpful to us, because the regulator, HIW, will—. It would be clearer to us what is meant by safer staffing levels, because at the moment, it's something that everybody supports, but actually, putting some sort of detail and guidance around that would probably help us, as regulated industries, in preparing for our inspections. We'd know what we were going to be measured against.

[391] **Darren Millar:** Because there'd be consistency in how you're measured against that performance.

[392] **Mr Rogers:** Yes.

[393] **Darren Millar:** What about the care home sector?

[394] **Ms Minty:** I think, probably, it would be better for care homes as well. We're in a slightly different position in that we're regulated by the Care and Social Services Inspectorate Wales rather than HIW, but one of the regular observations during inspections is, 'You don't have enough staff', and then we say, 'Well, how many staff should we have?' and it's, 'Well, you're the provider; you should decide, and then you should go to the commissioner and ask for the money that you need'. But, of course, the commissioner won't pay any more than a certain amount. And, certainly, Sarah Rochira, the Older People's Commissioner for Wales, in her recent review of residential care, has highlighted a need to start setting staffing ratios for residential care for social care practitioners, as well as—. Logically, that would extend to nurses. So, I think it would make commissioning a lot more transparent, and it would reduce some of the risk for providers if we did have some sort of understanding of staffing ratios.

[395] **Darren Millar:** And it would make those expectations very clear, then, so that you can justify the staff that you do have to any inspectorate or any other regime that might be there to police it. Okay; thank you.

[396] **David Rees:** Jenny.

[397] **Jenny Rathbone:** I just want to talk about money—[*Inaudible.*]–said something about how you've got to compete with the NHS in terms of things like career opportunities and sick leave. Can you just confirm that both the independent and third sector do pay sick leave? What is the nature of your contracts with your staff?

[398] **Ms Minty:** I imagine it would vary tremendously from individual employer to individual employer, but from most of the people I've spoken to, I believe that people receive only statutory sick pay. I don't know whether that would be the same in Linc, Anne?

[399] **Ms Thomas:** No, in Linc we pay all our nurses' sick leave, but that's not normal; generally, providers can't afford to do that, given the contract price that we get from the local authority and the health board.

[400] **Jenny Rathbone:** So, some people are on zero-hours contracts, are they?

[401] **Ms Minty:** I think that tends to apply more to domiciliary care. In care homes, people are usually on, sort of, 37-hour contracts or whatever.

[402] **Jenny Rathbone:** Because you do mention people working 60-hour weeks.

[403] **Ms Minty:** Yes, that's overtime.

[404] **Jenny Rathbone:** But that level of overtime can lead to sickness for people.

[405] **Ms Minty:** Yes.

[406] **Jenny Rathbone:** I really want to explore—. Obviously, there's always a price for most things. If you're in competition, what is the elasticity in your business to pay more in order to recruit or retain the nurses you need?

[407] **Ms Minty:** I think the basic issue is that, if you look at the different costs, a night in an NHS bed will cost the NHS £300, but a whole week in Cardiff and Vale would cost about £800. So you can see the difference straight away when you've got to pay wages out and try and make even a small profit. There's not a great deal of elasticity there—more I would imagine for some of the larger companies that can make economies of scale. But one of my concerns is the impact on smaller homes, in particular, that can't make those cuts, and the likelihood that we're going to lose some of those smaller homes and reduce the amount of choice that we have for people as to where they're going to live.

[408] **Jenny Rathbone:** Are you operating to different pressures in the independent sector? Presumably the people who commission your services are self-paying, in the main, whereas in the third sector they'll be mainly local authority nominated or from outside.

[409] **Ms Millard:** From the point of view of the acute sector and independent hospitals, the vast majority of our patients are self-funding or through insurance companies, so the funding issue is completely different. We have very few zero-hours contracts. Our staff tend to be contracted and we pay sick pay, so our terms and conditions are very similar to the NHS. Traditionally, we've had less trouble recruiting into roles because of that. There are certain issues within highly specialised roles, such as theatre, which can be difficult. It's difficult for the NHS as well as us, I hasten to add—there's a shortage of that area of nursing. So, we haven't had the same issues that the third sector have had with regard to that.

[410] **Jenny Rathbone:** So, in the independent sector, what impact do you think it would have on your business if we go ahead with this Bill?

[411] **Ms Millard:** The impact may well be if there was a greater demand for nurses and the pool of nurses has remained the same, then we are competing more for the same pool of nurses. If NHS requirements increase and yet the commissioning of more nurses to train is increased at the same time, then the pool of nurses is smaller and it becomes more difficult.

[412] **Jenny Rathbone:** Are you in a position to pay more, then, if there's a tighter pool?

[413] **Ms Millard:** It would be difficult, because obviously we have to ensure that we can pay our bills in the same way as anybody else does, but that's not to say it's completely out of the question. We would have to look at that closely.

12:15

[414] **Jenny Rathbone:** Okay. So, in the third sector, what would be the possibility? If you get this shortage of nurses, what are your options, in terms of paying more in order to recruit or retain?

[415] **Ms Thomas:** There isn't any money to pay more. The staff-funding part of our budget is already around 70 per cent of our total expenditure, so paying more to staff would mean having to charge more to people who use our services, and that would, probably, mean targeting people who have got their own money and would disadvantage those who are just as worthy of good nursing care but are unable to pay.

[416] **David Rees:** [*Inaudible*.]

[417] **Jenny Rathbone:** That's exactly what I'm exploring.

[418] **David Rees:** Okay. Can I ask a question to the independent healthcare association? In your evidence, you talk about using the National Institute for Health and Care Excellence safe guidelines, but your acuity tool appears to be based on your clinical experience and judgment, effectively. Clearly, the Bill does have a triangulation approach and it will require an acuity tool, so is there an issue, if it came into force in your sector, with looking at using acuity tools to enact it?

[419] **Mr Rogers:** I think that every national group—Nuffield Health and Spire—are developing their own national tools, because that's the era that we're in. So, I think the devil's in the detail; it will depend on what the actual detail is in the Bill. I think that, coming back to Mr Millar's question, in principle, we're very supportive. I think that our evidence says that we do support it in principle, but what the tool looks like when it comes out will, actually, determine whether or not it actually works for us as a sector.

[420] **David Rees:** Do you think there'll be any barriers to your sector if the Bill was introduced taking care of all healthcare in Wales—monitoring, compliance and legislative responsibilities?

[421] **Mr Rogers:** I think that, for the bigger organisations, we're already on the same lines. I think it may be difficult for smaller providers, which may find it difficult with scale issues for staffing ratios.

[422] **David Rees:** Care Forum, do you think that there are any barriers that you foresee if the Bill was implemented and extended the scope to include your sector, other than the fact that you might lose nurses?

[423] **Ms Minty:** Yes, I think that's probably the main—

[424] **Ms Thomas:** Yes, that's the biggest thing; it would need to encompass appropriate commissioning and payment for that level of nursing input. It's not that people don't want more nurses; it would have to be encompassed in the commissioning.

[425] **David Rees:** So, the commissioning arrangements have to ensure that there is funding to go with them. Darren.

[426] **Darren Millar:** Just in terms of the challenges, the health board have also raised this issue of recruitment challenges at the moment, which is a bit of a barrier for them to be able to meet the aspirations of the current guidance that has been issued by the chief nursing officer. If there were legislation to require certain staffing ratios or minimums, or if the acuity tool said you've got to have x, but you simply cannot find the staff, and health boards cannot find the staff, how do you think that the legislation ought to be able to react to that in a fair way, which doesn't penalise you for circumstances beyond your control?

[427] **Ms Millard:** That is a very real concern, it has to be said. The independent care sector care homes are amongst the most heavily regulated of all sectors already, and the small independent providers are quite vulnerable, really, to criticism from inspectors, commissioners et cetera. So, we would want to see some sort of protection built in, so that, if there was a safe level of staffing brought in and they were not able to recruit through no fault of their own, they would not face action that would, perhaps—. They'd have to be closed down if it wasn't safe, obviously, but they wouldn't be penalised.

[428] **Darren Millar:** Can I just ask one final question? You've obviously mentioned the fact that CSSIW are the inspectorate for your organisations, rather than HIW on the other hand, which has more of the health expertise, frankly. Do you think that there would need to be a common inspection regime for healthcare providers, given that you're providing so much nursing care, in terms of the policing of these arrangements, specifically?

[429] **Ms Thomas:** I think you could use the same tool. The different regulators could probably use the same tool, and agree what they were assessing and so on, but I just worry about people being penalised for not having enough nurses, because we've spent a lot of time focusing on recruiting the right nurses for the right jobs. I worry there would come a point where you just recruited anybody with a Pin number, so that you weren't told off for not having enough nurses. I think it's important, with all the stuff that's in the press and the work that the older person's commissioner's been doing about the quality of care, that we don't lose that in our effort to just say, 'We've got this many nurses.'

[430] **Darren Millar:** Okay, that's a very important point. Nobody's raised that with us, actually, about the quality of the staff pool that may still be applying for jobs out there. You've talked about the need for engagement on workforce planning. You say there's no engagement at all with the independent hospital sector at the moment in terms of workforce planning in Wales, for the planning of training of nurses. There is some engagement, isn't there, with Care Forum Wales and other representatives?

[431] **Ms Minty:** Yes, we've had some meetings with Welsh Government and made our concerns known. I think Dr Andrew Goodall is trying to, sort of, push that down to the health boards, as they're responsible for recruitment. But I think our experience is that their willingness to engage with us is patchy, shall we say? So—

[432] **Darren Millar:** Do you think there needs to be an amendment to the Bill to reflect on that and require the Welsh Government to engage with the independent sector to plan for the workforce, effectively?

[433] **Ms Minty:** Yes, I think so.

[434] **Ms Thomas:** Absolutely.

[435] **Darren Millar:** If you're going to be incorporated within this Bill.

[436] **Mr Rogers:** Just, sorry—[*Inaudible.*]

[437] **Darren Millar:** There's something.

[438] **Mr Rogers:** There is some. I mean, we do meet with them on a six-monthly basis and we have managed to get involved with some strategic planning groups, but it's still at the early stages, and we do want to take that further, because it's really important we're not competing with the NHS for the same pool of staff. Yes, you're right, it could change our pay rates, but we don't want to get into the business of actually draining the NHS of talent. We want to, kind of, work with them as a partner in developing workforce plans.

[439] **Ms Minty:** And we are all involved in nurse education by providing placements for our nurses within their training.

[440] **Mr Rogers:** Student nurses.

[441] **Darren Millar:** Okay, thank you.

[442] **David Rees:** I've got one question. You've indicated you think the Bill is something worthwhile. A question I would ask, perhaps, the nursing home sector is: is this the correct tool to actually deliver improved patient or resident outcomes for your sector? That's what's important at the end of the day. Is it the right tool to deliver for people?

[443] **Ms Minty:** It's not a standalone tool, is it? There is a much wider issue around the nursing shortages that already exist in care homes, which are down to commissioning, issues with relationships with local health boards and so on. So, this Bill alone wouldn't address those problems. Our main concern is about the unintended consequences of the Bill, rather than seeing it as a sort of cure-all.

[444] **David Rees:** It might not be alone, but would it strengthen the case?

[445] **Ms Minty:** Yes.

[446] **David Rees:** Any other questions? There are no other questions from Members. May I, therefore, thank you for your time and thank you for waiting for the extra bit longer, because we took a bit longer with the Minister? Thank you very much. You will receive a copy of the transcript for any factual inaccuracies you identify. If there are any, please let us know as soon as possible. Thank you for the evidence, which we'll now take into consideration.

12:23

Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod ar gyfer Eitemau 6, 7 a 12 ac ar gyfer Eitem 1 y Cyfarfod ar 25 Mawrth 2015

Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from Items 6, 7 and 12 of the Meeting and for Item 1 of the Meeting on 25 March 2015

Cynnig: *Motion:*

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o eitemau 6, 7 a 12 y cyfarfod ac eitem 1 y cyfarfod ar 25 Mawrth 2015 yn unol â Rheol Sefydlog 17.42(vi).

that the committee resolves to exclude the public from items 6, 7 and 12 of the meeting and item 1 of the meeting on 25 March 2015 in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[447] **David Rees:** The next item on the agenda is actually to move into private session. Therefore, I propose, in accordance with Standing Order 17.42(vi), that the committee meets in private for items 6, 7 and 12 of today's agenda, and for item 1 of the agenda for 25 March. Are Members content with that? Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:24.
The public part of the meeting ended at 12:24.

Ailymgynullodd y pwyllgor yn gyhoeddus am 13:32
The committee reconvened in public at 13:32

Ymchwiliad i Gamddefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 7
Inquiry into Alcohol and Substance Misuse: Evidence Session 7

[448] **David Rees:** Can I welcome Members back to this afternoon's session of the Health and Social Care Committee? This afternoon, we'll be continuing our evidence taking for the alcohol and substance misuse inquiry. We will have three sessions of witnesses. Can I welcome the first group of witnesses: Sue Goodman, who is the regional manager of The Wallich, and Antonia Watson, the chief executive of The Wallich? Thank you very much this afternoon for attending, and thank you for your written evidence as well. If it is okay with you, we will go straight into questions. We'll start with Gwyn Price.

[449] **Gwyn R. Price:** Thank you, Chair. Good afternoon, both. Could you outline the current barriers to developing a single pathway to recovery and how they can be removed, in your opinion?

[450] **Ms Watson:** I think a lot of it is about—. I mean, things work very well on the ground level, at the front-line level, but I think it's about seeing the bigger picture. So, we actually need to know exactly what's in each local authority area, how that fits into the overall Welsh Government strategy. In terms of developing a single pathway, I think a lot of it is to do with how services are funded—we sort of look at silos of funding homelessness, alcohol, mental health et cetera. I think we need to somehow bring the funding streams together, so we start looking at whole funding streams and whole people, as opposed to just a set of individual specific needs.

[451] **Gwyn R. Price:** People are getting lost through the net as they go from one to the other.

[452] **Ms Watson:** I think so. So, for example, a treatment service might be excellent, but then, leaving treatment, there is no clear pathway of where that person is going to move to—for example, into a recovery project. I think that's the missing link.

[453] **Gwyn R. Price:** Do you agree, Sue?

[454] **Ms Goodman:** I do, and just to add to what Antonia said, it's actually treating somebody as an individual, who often has complex needs. I think we tend to focus on one area. So, on substance misuse, there might be myriad issues, and, actually, it's about identifying what the whole needs are for that person. We don't do that; we just concentrate on one element.

[455] **Gwyn R. Price:** Yes, because we've taken evidence that, for instance, they can come out of prison and there is no follow-up to take them to the next level, and they're just abandoned virtually on the streets. Would you agree with that?

[456] **Ms Goodman:** We've got a project in Ceredigion for prison leavers, and we've had times when the prison leavers have just turned up on their own to our project without a clear support plan in place and are left. If they are trying to go into recovery or into a harm reduction model, it's not been laid out. So, I absolutely agree with what you're saying.

[457] **Gwyn R. Price:** Thank you very much.

[458] **David Rees:** Your evidence, along with other evidence we've received, indicates inconsistency across Wales. Are you seeing that in these types of services, whether it be for individuals who have come out of prison or other homeless groups? How widespread is that inconsistency?

[459] **Ms Watson:** I think, in terms of prison leavers, gaps are being plugged. I can only speak for the experience of The Wallich. In Bridgend, for example, we do a resettlement service for people leaving Parc, but that's almost working in isolation because it's a Big Lottery-funded scheme. It is not necessarily linked in at the strategic level at the local authority level. I think that that's the need. There are lots of these little projects happening, but it's about, again, understanding what's being provided in a local area, or to a local prison in this instance, and looking at whether that's the most efficient and effective way of providing services to that particular prison population.

[460] **David Rees:** So, it's quite variable across Wales.

[461] **Ms Watson:** Yes. We work in 17 local authorities, and there are probably different requirements in all of them.

[462] **David Rees:** Okay, thank you. Lindsay.

[463] **Lindsay Whittle:** Thank you, Chair. Good afternoon. I worked as a housing manager in this city and worked with Wallich Clifford and the Huggard centre as well. My experience, going back to when I first started work, was that it was mainly older people. Then it seemed to change to younger people, but I think it's going back to older people now. I wonder whether you could explain the particular problems of rehousing older people back into the community, in particular those who have either alcohol or substance misuse problems. For older people, it's probably mainly alcohol, I would have thought, but I'm not an expert on that matter.

[464] **Ms Watson:** Increasingly, there are multiple alcohol and drug use problems with some of the older people we're seeing now. Years ago, you were a drinker or a drug user, and never the two met. Now, I think there is dual use. In terms of older people, we have some projects like the Shoreline model. I think we've got 30-odd units in Cardiff. That houses people who are former street drinkers and part of street drinking gangs, and they tend to be older people, primarily men, who live together for a long time. Their drinking tends to reduce and certainly there are health benefits of that sort of long-term supported housing. To move on from that scheme is difficult and not what they would necessarily want. For people who aren't

from that sort of street drinking gang community, I think the issues are that sheltered housing and extra-care housing aren't geared up for that sort of client group—someone who is drinking or certainly someone who is taking drugs. Sheltered housing is generally for more the more traditional person aged over 50 or 55 without those sort of high support needs. So, to get people into that sort of accommodation, there needs to be a lot of work with providers of sheltered and extra-care housing.

[465] I think the other issue that we find problematic in supported housing is that, with older people, it's around care needs as well. So, we actually need care and, the way we're funded, supported housing being joined up so we can sustain someone in their accommodation and so they get the element of physical care that they need. That increases with age, obviously.

[466] **Lindsay Whittle:** Thank you for that. Through you, Chair, it's extremely interesting—my experience of working with many of the tenants that we'd house from hostels was that, for the first six months, everything seemed to be going fairly well, but then there was that sudden catastrophic sort of dip in the support, really, because I think people think, 'We've put people back into the community now. Our job here is done', and that's when it slips by. Do you think there's a case for really extending that support?

[467] **Ms Watson:** Yes. Again, as we've said earlier, it needs to be around the individual, but, clearly, long-term support is costly in terms of supporting people, and it's moving towards quick interventions and moving on to the next person, but the long-term success of that, I should imagine, isn't that great. But, I think, one of the things that certainly front-line providers could be leading is looking more at developing meaningful activities once people move on—looking at volunteer opportunities, work opportunities, and starting to look at people supporting themselves as well, in befriending programmes. I think there's a role for certainly front-line providers to get involved and to promote that.

[468] **Lindsay Whittle:** I have a final question, through you, Chair. You've come beautifully to my next question, which is working with—. Whenever people are housed there's normally a bit of an outcry in the community and you have to placate that. Do you find working with residents' associations in particular really helps this situation?

[469] **Ms Watson:** It can do. We've got some good examples. In Llanelli, we have a young persons hostel, and that had a difficult time in the community at one stage. That works very well with the local tenants' association. We have pockets where we have difficulty, primarily outside of the larger cities, where there is an absolute hatred, I would say, for wanting to have a scheme. In Wales, they're mainly small schemes of local people that have alcohol, drug, mental or any sort of issue. There is a big community response in certain areas against our services. Our argument is that these are local people; we're not shipping people in from England or other local authorities. These are local people that need accommodation and support.

[470] **Lindsay Whittle:** Yes, these are our people.

[471] **Mr Watson:** And that is a problem and I don't know how that—

[472] **Lindsay Whittle:** Yes. I know it's tough. Thank you.

[473] **Ms Goodman:** You mentioned older people and being in hostels. We run a project in Anglesey called Housing First, and that's a model where people don't go into hostel accommodation. It's for over-25s. The average age is 49, and it's actually taking people who are homeless off the street in Anglesey and placing them into their own home and providing intensive support. It's been a huge success. We did it as a 12-month pilot and it has been extended. That's providing really, really fantastic support. So, someone can stay in their own

tenancy in their own home.

[474] **Lindsay Whittle:** Thank you very much.

[475] **David Rees:** Alun?

[476] **Alun Davies:** Thank you very much, Chair. Reading through your written evidence, you appear to be saying that the Welsh Government strategy is good but the implementation doesn't work.

[477] **Ms Watson:** I mean, the strategy is great, but, from a front-line perspective I don't think we would necessarily—. Well, we wouldn't look at the strategy. I don't think it's embedded in the—

[478] **Alun Davies:** Sorry, you say that you wouldn't look at the strategy.

[479] **Ms Watson:** In a way, we wouldn't have to look at the strategy. As a front-line worker, working with someone with an alcohol and drug problem, we wouldn't necessarily look at the strategy. It's not embedded into our funding streams. So, our Supporting People grants are not, I don't think, integrated with the strategy, which they could be. So, if you look at that whole service, it should be making reference to this, looking at—. I think the local authority has a bigger role in ensuring that our services—all the local providers—are working towards the Government strategy.

[480] **Alun Davies:** So, can I come back on that? So, what you're saying is—because I'm not sure that it's entirely clear in your written evidence—that, within Government, there is a lack of hard thinking, if you like, and a lack of a joined-up approach.

[481] **Ms Watson:** Or holding local authorities to account.

[482] **Alun Davies:** Well, what you've just said in answer was that, in terms of some of your grant funding, the strategy doesn't seem to have been integrated into that.

[483] **Ms Watson:** Yes, I think that's right.

13:45

[484] **Alun Davies:** So, there's one arm of Government saying one thing, and another arm of Government doing something different. You know, that's the impression—that is what you're saying.

[485] **Ms Watson:** Yes.

[486] **Alun Davies:** So, it's not simply that there is a lack of structure, if you like—structured thinking or delivery—of working between the Welsh Government and, say, local government; there is a lack of that same structure within Welsh Government.

[487] **Ms Watson:** I don't think it's a lack from the Welsh Government, if you read the strategy document—great. But I think how that then gets translated to the local government level and then further down—

[488] **Alun Davies:** Sure, but you've just also said that that strategy isn't integrated into grant funding. So, there must be some sort of structural disconnect within Government as well.

[489] **Ms Watson:** Right, yes.

[490] **Alun Davies:** Fine, so we understand that. So, you've got this disconnect within Government: you've got the theory on one side and the practice on another side. I presume there's some relationship or resemblance between those two things, but then there is another structural disconnect between what comes out of Cathays park and what is actually delivered, for example, in my constituency in Blaenau Gwent, yes?

[491] **Ms Watson:** Yes, I think that's—. Yes.

[492] **Alun Davies:** Can you, from your perspective, give us some reasons for that and why you believe there are those two, absolutely critical, disconnects, from what you see where you are?

[493] **Ms Goodman:** I'd like to say something. I think one of the key issues—. I'm actually on the area planning board forum—the provider forum—in north Wales, so I am involved in the strategy, because I sit on one of the groups in north Wales and I cover across the six local authorities. Part of the problem is that we haven't actually mapped out all the different services that we provide with the different funding streams. So, that's where I see the disconnect—that, actually, in north Wales, where I work, I know that there's a myriad of different funding streams. So, there's Communities First, there's section 180 money, there's Supporting People money, housing pay for some services and there's substance misuse money. So, there's lots of money, there are lots of different projects going on, and it's never been mapped. So, it sits in silos. If it was all connected—and this isn't always popular—but if there was one funding route, you could then provide those services across the area. That's where I think it's disconnected.

[494] **Alun Davies:** So, I presume, therefore, that you, being people in individual silos doing very similar things, also have some level of duplication as well.

[495] **Ms Goodman:** We've just had a section 180 review with the Welsh Government, and—

[496] **Alun Davies:** What does that mean?

[497] **Ms Goodman:** It's a funding stream, largely for preventative work across Wales, and they've been reviewing that service to make sure that there isn't duplication. I think there has been some duplication, and I'm sure there is some duplication in other services.

[498] **Alun Davies:** Because one would presume that, since you don't know what services are being provided, and your assumption is that the Welsh Government don't know this either—. You are saying that you don't know, Mrs Goodman, and that's your perspective, which is fine and reasonable, but is your presumption that Welsh Government doesn't know this either?

[499] **Ms Goodman:** I don't think it's ever been mapped across Wales—the different funding streams and the different services provided for recovery, harm reduction and prevention.

[500] **Alun Davies:** Again, from your perspective—your perspective is absolutely invaluable—when you're dealing with the Welsh Government, are you dealing with one department or two departments? Are you dealing with a number of different officials? What's your experience of that relationship?

[501] **Ms Watson:** In terms of Welsh Government, we only tend to deal with one

department of the Welsh Government, because that's regarding the section 180 funding, which is direct from Welsh Government. The rest is Supporting People—

[502] **David Rees:** With local authorities.

[503] **Ms Goodman:** It's local authorities.

[504] **Ms Watson:** For local authorities—

[505] **Alun Davies:** Sorry, can you be more clear? I don't know what section 180 funding is.

[506] **Ms Watson:** Sorry—it's Welsh Government funding for prevention of homelessness.

[507] **Alun Davies:** And where does it come from? Which department?

[508] **Ms Watson:** The housing—

[509] **Alan Davies:** The housing department. Fine, so you don't have any relationship with health or social services, or anything with local government?

[510] **Ms Watson:** No. It's primarily housing, social care—.

[511] **Alun Davies:** But I would presume that the health department, in terms of preventive and service provision, would also be having funded streams available for this sort of work.

[512] **Ms Watson:** In our experience at The Wallich, health tends to sit outside of what we do.

[513] **Alun Davies:** Do you want me to carry on?

[514] **David Rees:** If you want to.

[515] **Alun Davies:** I just find this fascinating, because we look at the Welsh Government, and we see what goes on in Cathays park and elsewhere, but I'm interested in what is coming from you. I would have anticipated that you would have a relationship of some description with the health department, and you don't have any relationship.

[516] **Ms Goodman:** We do in tier 2.

[517] **Ms Watson:** We do in pockets. So, in Wrexham, for example. Sue, if you'd like to—

[518] **Ms Goodman:** Yes, we built a tier 2 service in Wrexham on Grosvenor Road, and that was capital funding through health. We run it as a partnership, partly with health, and with the council, and with Wallich staff. So, it's a fantastic partnership on a health project. So, we do small pockets, and I run a recovery project in Carmarthenshire, and that's very much assisted; although it's Supporting People money, we work very closely with health. So we do, in pockets, around Wales, but it's not one of our main funding streams.

[519] **Alun Davies:** And it's on a local basis.

[520] **Ms Goodman:** Yes, it's very local.

[521] **Alun Davies:** Does that go through the health boards, or does it go directly from Government?

[522] **Ms Goodman:** It's through the APB.

[523] **Alun Davies:** Through the area planning board. Okay, fine. So, in terms of understanding this—I hesitate to call it a structure, having listened to what you've said over the last few minutes—the structure of services, it's little wonder, I would suggest, that a strategic document from Cathays park doesn't deliver on the ground. It would seem to me that what you're saying is it can't deliver because, structurally, we don't have the structures to be capable of delivery.

[524] **Ms Watson:** Yes, and our structure, if we're talking about the silos, ours is primarily, 90% of it would be looking towards Supporting People teams within local government.

[525] **Alun Davies:** Okay, fine. So, understanding where we are today, draw me a picture of where you would want to be.

[526] **Ms Watson:** Integrated. We'd want to see three clear strands, I think, so it would be easy for the people we support to move through. It would be for what they wanted at the time they want it—and I think that's quite important when you're talking about homeless people. It would be the prevention side, so, clearly, that early intervention, prevention, preventing people from getting into some of our services, preventing people from getting on the streets. Then, acknowledging that there are some people that are there, that we are supporting in that accommodation and floating support, and making sure that they have access to the services that they require, particularly things like GPs, which I think again is crucial when you're looking at the homeless population. Then, that there is appropriate harm reduction across the sector, not just in certain—. So, it's about having a combination: the harm reduction; allowing things like injecting drug use in hostel accommodation; also having some dry provision. So, having that range of provision, again, tailored towards the individual, and then at the other end, with someone who's going into treatment—we see people going through treatment seven times, on that sort of cycle, which is a complete waste of time and resource—and having proper structured recovery, so that when people leave treatment, there is somewhere, hopefully, where they can have a chance to succeed in their recovery.

[527] **Alun Davies:** Okay. In terms of management, I accept what you just said, but in terms of the management of that integrated approach, you have there a number of different interventions: you have yourselves in the third sector; you have a GP with the health board; and, you have social services, I'd probably suggest, in local government as well. Now, there are a number of different service providers, and we can argue about whether there should be more or fewer—I'm not going to start that on a Thursday afternoon—but how would you expect that to be structured? Because at the end of the day, if I was going to be managing that service, I would want one person to be responsible for delivering that joined-up approach.

[528] **Ms Watson:** Maybe that's where the APB—I think they're relatively new—would have, hopefully, that overview that you're thinking will work, in mapping that more effectively than is happening at the moment. So, I think if you've got all of those people represented, and maybe one person, I don't know—one local authority person—taking overall co-ordination to make sure that that strategy is implemented, and that the right people are at the table, I think that's—

[529] **Alun Davies:** I'm not convinced by 'accountability by committee'.

[530] **Ms Watson:** Okay. No.

[531] **Alun Davies:** You know, if I wanted to know, for example, that those services were being delivered in north Wales—where we started—I would want to be able to go to one

person and say, ‘You tell me what is happening, how have these services been integrated, and tell me what you’re doing to deliver’. As soon as you get into a committee, then, you know, there’s always that danger of pass the parcel when it comes to accountability.

[532] **Ms Watson:** Yes. That’s true.

[533] **David Rees:** Okay. Right, we’ll leave it there. You indicated that you’re currently doing that mapping exercise at this point in time. So, you can start looking at the collection of services and we can start looking at what can be done and who then becomes responsible.

[534] **Ms Goodman:** Yes, I think it’s crucial, and I think it’s not about—. It might be a number of services because, you know, GPs are separate; they’re through health. So, you have to have a number of services involved, but it’s actually saying to an individual—treating people with respect and dignity, with what they want, which strand they want—so you actually make a contract with an individual person to say, ‘If you want recovery, this is what we’ll deliver’. And, it’s not one service, because one service cannot provide it, because we’re not GPs. So, if somebody says they want to go into recovery, but, actually, they need a detox, rather than have seven detoxes, what we’ve found in some areas is you have an agreement with an individual that we will, collectively, provide that service. So, you go into detox, and then you go into recovery, and then you find sustainable housing, and then you provide ongoing support. So, it’s actually a contract with an individual person; it doesn’t matter who provides that service, as long as it’s provided, and it’s provided well for that person.

[535] **Alun Davies:** Can I carry on with that? That interface is absolutely essential, and I don’t disagree with you about that, but, what I’m concerned about is how you create the conditions where that interface—that meeting—can take place. Because, one of the issues we all know about many people who have issues with alcohol is that they might not be registered with a GP, and finding a GP if you’re homeless is particularly difficult, so that route can be, quite often, closed. Quite often, when I’ve spoken to people in local government, they’re dealing with people—particularly people who’ve been homeless—who’ve been through a journey of abuse and the rest of it, and that intervention should have taken place much, much further down the line. I’m still not clear as to how you can bring that interface between a person and a service provider much, much further upstream—an earlier intervention—and who would do it.

[536] **Ms Watson:** I suppose some of it would be age related. It’s probably easier to look at some of the prevention with young people—trying to target them early—than older people. I suppose it’s where you have information. I think GPs have a big role in this, actually, because, we did some research in Denbighshire with rough sleepers, looking at barriers to accessing services, and 80 per cent of those rough sleepers were registered with a GP, and that was their first point of contact with access to services. So, I think there’s a big role—. I know we often say people don’t have GPs et cetera, but that piece of research showed that the street homeless people did. So, GPs were fundamental; they held that gateway to access the service, detox, you know. So, I think there is something about skilling up. Where do people have contact? GPs, at the benefits office, in libraries. It’s about, there, can we look at training people differently to provide that information? Where there’s gaps in services, people fill those, be it the third sector or be it the church group providing night shelters. There’s a whole range of people plugging gaps at the moment, and it’s looking at how we get information to them, so they can inform the people that they work with.

[537] **Ms Goodman:** Just to add to that, on your point, local authorities have the statutory duty, so when somebody presents themselves as homeless—which is what you were saying—that’s where they go. So, the first point of contact is the local authority department; they will go to the homeless team and say, ‘I’m homeless’. So, some people, if it’s a family, will usually be placed—one hopes. So, they will be placed, and what you’ll find—you’ll all

know—is that it's the single male group are the ones that they will not have a statutory responsibility to house, and that's where we pick shelter.

14:00

[538] Different agencies across Wales will pick somebody up and do their best to find somebody temporary accommodation. So, that's how you pick somebody up, but there is no one single agency that does that. What we'd need to have is, when we pick somebody up, that we give them a contract and say, 'We will see you through this to what you want, whether it's recovery or it's a harm-reduction model'.

[539] **David Rees:** Darren.

[540] **Darren Millar:** Thanks, Chair. I just want to ask you, if I can, about the different people groups that seem to manifest with substance misuse problems, particularly alcohol problems. You've made reference in your evidence to young people, older people, to prison leavers, as well, and to homeless groups. To what extent are the veteran population appearing in the mix, as it were? I assume they can fit into any of those categories, given the high prevalence of former ex-servicemen and women who seem to have problems with alcohol in particular.

[541] **Ms Watson:** As an organisation, we don't see huge numbers of veterans coming into our services, which is probably quite different to what a lot of agencies say. However, there are pockets of people from forces background. For example, in Ceredigion we're developing an accommodation project for veterans, which Sue is responsible for.

[542] **Ms Goodman:** We know that there have been at least five people who are homeless veterans around Aberystwyth in the last couple of years, and there's probably more because there'll be a hidden need. We've tried to put a project together for four units of accommodation for armed forces personnel. Unfortunately, we were turned down for funding by the armed forces community covenant grant in their head office. So, regarding the Ceredigion armed forces community covenant grant, I went to a meeting and they approved it, but it was turned down nationally. So, we have now got an empty property on Chalybeate Street in Aberystwyth.

[543] **Darren Millar:** And that was a grant for the operation of the premises rather than—

[544] **Ms Watson:** No, it was a capital grant.

[545] **Darren Millar:** A capital grant.

[546] **Ms Goodman:** Yes, to convert it into four units.

[547] **Darren Millar:** But you clearly identify that there is a slightly different need or a slightly different way of catering for the veteran community. Therefore, you needed a veteran-specific service in the Aberystwyth area. Is it always appropriate to accommodate them together, as it were, rather than with other groups?

[548] **Ms Watson:** My personal view is that most communities should be mixed, but I couldn't say from The Wallich evidence as we don't have that evidence to draw on, to say. We just don't have the numbers coming through, or that we know of, but that might be to do with our monitoring.

[549] **Darren Millar:** But you clearly identified a need for a veteran-specific project in the Aberystwyth area.

[550] **Ms Watson:** That was through the local authority. That would have been their push, as well.

[551] **Darren Millar:** But the barrier was—. I'm assuming it's the armed forces community covenant grants from the Ministry of Defence that you were trying to secure. It would helpful, perhaps, if we could get some research about what proportion of that has ended up in Wales, actually, compared to elsewhere, to make sure we're getting our fair share. I know also that a number of other organisations focused particularly on the veteran population, but, in terms of prison leavers, what's your experience with prison leavers? I know that they can be a very difficult group to rehome. You mentioned some good practice that's going on in south Wales in your evidence, but I know that you've got a north Wales perspective as well. We don't have prisons in north Wales yet—

[552] **Ms Goodman:** We will do.

[553] **Darren Millar:** —we're going to get one—but we do have to resettle people back into north Wales who've been at prisons over the border. So, how joined up are services for those sorts of individuals, given that, obviously, health services are devolved here for prisoners, whereas the prison service health responsibilities lie completely over the border with the UK Government? Is it a barrier?

[554] **Ms Watson:** I think, actually, there's a good opportunity at the moment. We've obviously got the working links under the Transforming Rehabilitation happening now, and we've got the housing Bill coming in, so there is, in a way, quite a joined-up approach in some respects. You know, we've got Prison Link Cymru, we've got Justice Cymru—which is housing associations and us—looking at an offer across Wales and being that sort of mediator between local authority and working links and providing a service to people leaving prison who need access to, for example, the private rented sector. So, that model's happening on a small scale and we're scaling that up to look at an offer across Wales. I think there's an ideal opportunity now, because people are looking at everything—everything's new in that sector.

[555] In our mainstream homeless hostels and night shelter, we would be seeing significant numbers of people with offending histories. It's not a barrier to our services, and it goes hand in hand with substance misuse, alcohol—

[556] **Darren Millar:** I suppose the point I'm making is: where somebody enters the prison service with a significant substance misuse problem—alcohol-related problem, in particular—how is that risk provided for when somebody comes out of prison in north Wales? It appears that, again, there's some good practice in the south, but I'm concerned that prison leavers from prisons over the border may be getting a slightly rawer deal.

[557] **Ms Watson:** I think Prison Link Cymru works in some of the north of England prisons, so there would be that link to north Wales, resettling people back, and actually, the women's prisons—

[558] **Darren Millar:** So, the good practice is consistent across, then, is it?

[559] **Ms Watson:** I'd say that there is work going on.

[560] **Darren Millar:** Okay.

[561] **Ms Goodman:** Just to add to that. I think, when the prison is built in Wrexham, there will be a lot of work to do to make sure that it's seamless, and I think that there is a lot to do, because it will be a big issue for Wrexham.

[562] **Darren Millar:** And just one final question in relation to—. You've mentioned the sort of wet and dry hostels, and the differences between the two—one being abstinence-based and one not being abstinence-based. What's the proportion—[*Inaudible*]—you know, wet versus dry hostels in Wales?

[563] **Ms Watson:** I don't know in Wales. Sorry, I don't know.

[564] **Darren Millar:** Okay.

[565] **Ms Watson:** For us, it's predominantly wet.

[566] **Darren Millar:** It's predominantly wet.

[567] **Ms Watson:** I would say that that probably isn't the same as a lot of providers.

[568] **Darren Millar:** Most providers.

[569] **Ms Goodman:** I would say that registered social landlords, housing associations are dry. I can't think of any where you can go and drink.

[570] **Darren Millar:** But you're suggesting that there's inadequate provision of wet hostels in particular, aren't you? So there's a need for an expansion of the wet hostel movement—if I can call it that.

[571] **Ms Watson:** I think so. Newport commissioned some research back in November, December, around the need for wet provision in Newport. So, again, there are pockets; it's not massive. We've got 30-odd units in Cardiff. I think, for us, we'd never want to see anyone excluded from a project because they drink, or because they use drugs, because that's just going to—. You know, there's that cycle of homelessness. So, it's opening up and, again, looking at that person, not having blanket bans on things, unless it purely is about, 'This is a recovery house and, if you drink, then we need to find somewhere else', because the whole house—

[572] **Darren Millar:** Yes, but it needs to be there, in terms of the suite of provision that's available.

[573] **Ms Watson:** That's it—the suite of provision. That's what we'd advocate.

[574] **Darren Millar:** Thank you.

[575] **Ms Goodman:** If I can just add to that, I think, you know, why should somebody—. If they want to have a drink, why should they be excluded from housing, if somebody wants to have a drink? It doesn't seem right that they can't have a drink but they have to live somewhere and be dry. It doesn't seem quite natural for quite a few people. Recovery housing, obviously, is where people have made a choice to abstain, and I'd like to see more recovery houses across Wales, linked to detox.

[576] **David Rees:** We've come to the end of our time. I've just got one question, and it's a simple question. Obviously, the Government has issued a white paper on public health. In that was a consideration of minimum alcohol unit pricing. I just wondered what your views would be on that, if it appeared in the public health Bill.

[577] **Ms Watson:** Minimum pricing, did you say?

[578] **David Rees:** Yes.

[579] **Ms Watson:** I mean, I would have to say, or we would have to say, that it's a good idea. That's all I'd have to say, really, on that.

[580] **David Rees:** Thank you for your evidence this afternoon. You've helped us a lot. You will receive a copy of the transcript for any factual inaccuracies you might identify; please let us know if there are any. Once again, thank you very much.

[581] **Ms Watson:** Thank you.

[582] **Ms Goodman:** Thank you.

[583] **David Rees:** We're scheduled to break for five minutes. Are witnesses ready for the next session? If we have five minutes, then we'll get the witnesses in straight away.

Gohiriwyd y cyfarfod rhwng 14:09 a 14:13.
The meeting adjourned between 14:09 and 14:13.

Ymchwiliad i Gamddefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 8
Inquiry into Alcohol and Substance Misuse: Evidence Session 8

[584] **David Rees:** I welcome Members back to this afternoon's session, where we will continue our inquiry into alcohol and substance misuse. Can I welcome our next set of witnesses, Stephen Coole, the NUS Wales director, and Lucy-Ann Henry, alcohol impact programme manager for NUS Wales? Welcome, and thank you for the written evidence we've received. If it's okay with you, we'll go straight into the questions. Gwyn.

[585] **Gwyn R. Price:** Thank you, Chair. Good afternoon, both. Could you tell me whether universities are doing enough to tackle alcohol and substance misuse among the students, both on and off campus?

[586] **Ms Henry:** Can I just mention I'm from NUS UK, not NUS Wales? I've been managing the alcohol impact programme. So, I guess what we would say is we're working at the moment with seven pilots and, prior to that, some of the research that we had was saying that, actually, British universities' alcohol policies were quite mixed. So, what was being done was very varied across universities. In quite a lot of the universities, there wasn't one sole person who worked on alcohol as well. So, that's something we're trying to create with the alcohol impact programme.

14:15

[587] There is a willingness for this in universities, and there is a need for this, I think. What I'd also say is that, kind of, in terms of other policies, students unions—from some of the research that we've done—two thirds of our, kind of, welfare officers had also said that there wasn't a clear alcohol policy there as well. I don't know if you want to say anything else.

[588] **Mr Coole:** No.

[589] **David Rees:** One of those pilots is actually in Swansea, isn't it?

[590] **Mr Coole:** That's right.

[591] **Ms Henry:** Yes. One of the pilots is in Swansea at the moment. I mean, in terms of

me being able to now give a current picture, we're obviously only working with seven pilots, and only one of those is in Swansea.

[592] **Gwyn R. Price:** You say in your paper that you feel sometimes that there's not a priority among university staff towards the problem of alcohol.

[593] **Ms Henry:** Yes. I think that was, again, from the research that we'd conducted. It was, kind of, smaller research that we'd conducted. What we're trying to do with this programme is gather a current picture. As part of alcohol impact, we've also done some qualitative interviews with staff—senior management staff, students unions—to kind of gather that picture as well. But, I think, actually from the information that we have from rolling out the programme so far, there does seem an appetite for this and for this type of approach as well.

[594] **Gwyn R. Price:** Okay. But it's not really consistent across all universities.

[595] **Ms Henry:** From the kind of information that we have, the way that it's kind of—. Yes; the way that alcohol is dealt with isn't as consistent now, I think. That's why we want to try to create this kind of accreditation.

[596] **David Rees:** Pulling together.

[597] **Gwyn R. Price:** Thank you.

[598] **David Rees:** Okay. Darren.

[599] **Darren Millar:** Yes. Can I ask you, we've heard from Public Health Wales that there are an increasing number of students who are choosing to abstain completely from alcohol? You would concur with that view.

[600] **Ms Henry:** What I would say again is that we're in quite a difficult position here, because, in terms of the research, I'm not in a place where I can share all of the research that we've already gathered. We're kind of not at the end of our pilot. So, we have found—I can generally say—that we've found that there are quite a lot of non-drinkers as well. I guess that what we're trying to do is to try and understand that population. So, as part of our criteria, we're asking specifically for universities to do segmentation work to find out about the different groups within, and what that picture actually looks like, so that they can then go on and, obviously, meet the needs of those different groups.

[601] **Darren Millar:** But something will have triggered that response in them, won't it, to make that conscious decision not to drink?

[602] **Ms Henry:** Yes.

[603] **Darren Millar:** I know it's early days in terms of the research, but what sort of themes are emerging in terms of why they've made that decision? Is it cost? Is it impact on their studies?

[604] **Ms Henry:** One of the things that we were talking about earlier, and from some of the research and what students have said, is that in terms of £9,000 fees, I think students are perhaps demanding more from their universities in that way.

[605] **Mr Coole:** Yes. There's also, I would suggest, a shift in culture. So, in particular, our students unions themselves are places where students will go to congregate to talk about study and to buy coffee maybe more than alcohol now. So, there's been a bit of a shift in culture

there, I suppose, in how students actually socialise within the spaces within students unions and within universities. We have noticed that.

[606] **Ms Henry:** Yes.

[607] **Darren Millar:** But essentially you are suggesting that, you know, the university tuition fee issue—or the debts that people might come out with as well as the result of their studies—is potentially having a beneficial impact in terms of reducing the alcohol consumption of students.

[608] **Mr Coole:** Potentially; yes.

[609] **Ms Henry:** Yes. Potentially; but we'd need to finish our kind of research, specifically, to be able to answer that.

[610] **Darren Millar:** Okay. That's all I wanted to ask.

[611] **David Rees:** Lindsay.

[612] **Lindsay Whittle:** Yes. I believe that there are many responsible students, and there are some who will not be so responsible for a small part of their lives but go on to become very good citizens. It is about ensuring that those who do misbehave through alcohol actually stay safe. Because, you know, it's a part of their lives, and I won't say it's a matter of growing up because they're adults anyway, but, you know, it happens. I like the safer taxi scheme, which I think is important. I'm wondering what the students union has done to persuade that to occur at universities in Wales, because I know my own daughter benefited from that when she was in university in Bath. I think it's important that you look at these new psychoactive substances that we've just had a report on this week, because there are grave dangers there. It's not all about alcohol these days; it's about other substances as well. I wonder what the NUS are doing to help in that way, please.

[613] **Mr Coole:** Sure. I think, one of the things that we need to do off the back of this is have a look, through the work that Lucy-Ann's doing, at the different activities that are happening locally, because I don't think there's a consistent approach to how unions and universities are necessarily tackling this together. It very much depends on the local circumstances, who is responsible for what between the students union and the university. So, there are very different approaches and NUS plays a kind of supportive role raising awareness around some of the issues and supporting unions with their local practice. Being a membership organisation, we haven't got any national policy currently on this, so there isn't that kind of mandate, if you will, to say 'This is what we've got to try and do, nationally'. So, potentially through the findings of the pilot work, we might be able to get a bit more of a clearer picture and a clearer vision of what we want to achieve across Wales in total.

[614] **Lindsay Whittle:** That's good.

[615] **Alun Davies:** I spent 20 years living in a university town in Aberystwyth. It's dominated by the university in a way that Cardiff might not be. One of the changes in patterns of behaviour that I've seen is certainly the more coffee-shop approach, which wasn't there when I was a student, but also structured alcohol-based activities in a way that I find quite shocking. You know, the Carnage approach to different things where you've got a very aggressive approach to alcohol, which is unique to the student community. You know, you don't see that—. I can't think of anywhere in Blaenau Gwent where you have this sort of structured, organised approach to alcohol. To me, that culture is something that is quite disturbing. We have a cultural attitude to and relationship with alcohol in Wales particularly, which is somewhat different to other places. We do have a culture that is based on alcohol to

some extent—to a lesser or greater extent. But some of the stuff that I've seen amongst the student population is different to that. It is that very aggressive socialised approach based on alcohol. Are the NUS taking steps to address some of those issues? Do you agree with me that it is an issue?

[616] **Ms Henry:** Yes. So, in terms of something like Carnage, we do have a specific policy on that. NUS worked with Drinkaware and also with ACPO on that, looking at ways that students unions can address those issues, because we know about the impacts of what happens on those sorts of things, and there has been anti-social behaviour and different things that have happened on those. It's also part of our criteria as well to ban, basically, those types of events. It is not something we would support. We know that they're often large-scale drinking events as well.

[617] **Alun Davies:** So, what actions have NUS taken on that?

[618] **Ms Henry:** We've got specific policy on that. There's guidance that I can send through that's specific guidance on bar crawls that we would provide to unions, which, as I said, we've worked on with the police and with Drinkaware as well.

[619] **Alun Davies:** Okay.

[620] **David Rees:** Darren.

[621] **Darren Millar:** I just wanted to go back. We were having a discussion before about the impact of tuition fees. It strikes me, then, that perhaps students are more price-sensitive than many other parts of society when it comes to what they are consuming, whether that be food, drink or anything else. So, given that the Welsh Government has suggested that it wants to bring forward minimum alcohol pricing in Wales, do you think that that will potentially unfairly penalise some of those responsible members of the student community who just have the odd occasional drink? Will it sit rather uncomfortably with them?

[622] **Mr Coole:** I think there'd be a mixed response. That's my initial reaction to that. If we were to put that question out to students unions, I do think—with us not having a policy position on that, as I said—I do think that, when we pose that question to students unions, we'll get a mixed response.

[623] **Darren Millar:** So, you reckon a lot of them would still support minimum alcohol pricing?

[624] **Mr Coole:** I think some would. Some others may not.

[625] **Darren Millar:** Okay, but it's not a question that you have put out there—

[626] **Mr Coole:** It's not a question we've put around. We should say as well that, as part of our willingness to support this moving forward, if there are some specific questions we could do some consultations on or some further research, NUS Wales is certainly more than happy to work with our members on that.

[627] **Darren Millar:** Am I right in saying that some retailers would give discounts on alcohol to students, to NUS card carriers?

[628] **Ms Henry:** Yes. Again, this is something else that forms part of our criteria. Our criteria span many different things and include that. I guess that one of the things that we found in one of our pilots is that party packs were being provided to students, so when they move into new houses, they are provided with these party packs, and they include alcohol.

One of the things that that students union has worked towards is getting different things being provided, so it's not focused, again, on alcohol.

[629] **Darren Millar:** Okay; thanks.

[630] **David Rees:** Your evidence is heavily focused on alcohol, but, of course, this is on alcohol and substance misuse. What evidence do you have on the relationship between alcohol and drug misuse? Is it polysubstance misuse? Does one lead to the other, you know, and what actions are you taking about actual drug misuse?

[631] **Ms Henry:** First of all, I'd just say that we don't have specific research that we've currently done. I guess individual students unions and universities would be able to give you kind of a more current picture, in that sense.

[632] **Mr Coole:** For sure, and it links back, I suppose, to it being NUS Wales or NUS UK supporting students unions locally with what approach they're taking. I go back to, I think it was 2010—NUS Wales specifically worked on a Government-funded project with Frank. So, there are instances where we've done things on this before, but, again, without that mandate currently, we've got to work on supporting our local members with whatever activities that they're taking on, whether it's on alcohol or substance misuse.

[633] **Ms Henry:** One of the things that we were advised—. We have an advisory board as part of alcohol impact, and one of the things that had been said there was to keep alcohol impact as alcohol impact, rather than alcohol and drug impact, in terms of diluting the kind of approach that you're going for. So, we give the option to students unions to have bespoke criteria, and we thought through the idea of having current research around drugs and for that to be done. But, yes, in terms of actually including that as part of our criteria, we were, kind of, advised, and took that advice that we shouldn't, as part of the picture.

[634] **David Rees:** Lindsay.

[635] **Lindsay Whittle:** I just wanted to ask, Chair—I've only ever been to one freshers fair in my life, and that was last year. I think I was the oldest one there. Are you part of any induction programme for new students at universities? I assume there are induction programmes by the academics.

[636] **Mr Coole:** I mean, linked to what Lucy-Ann was saying, we deal with such a breadth of things with students unions. Obviously, the local students union will organise their freshers fair, and then NUS Wales will have a different role in terms of what they want to use us for, whether that's our green impact initiative, whether it's to go and train a new set of course representatives, or whatever it might be. So, our intervention very much depends on the request that we would get in for support with that specific freshers fair.

[637] **Lindsay Whittle:** Thank you.

[638] **Darren Millar:** Just thinking about early intervention for those students who might be having problems: what sort of support do you give to the wider student body to help them identify when a friend or a colleague may be getting into some difficulty and might need signposting to some support and help?

[639] **Ms Henry:** I think, again, with that, it would be specific student services on campus. So, I don't think NUS would be giving that advice.

[640] **Mr Coole:** I do wonder if there's, potentially, some work to be done there, actually, about prevention. Often, students unions are the first port of call. Where something has gone

wrong or someone has an issue, they will go through their students union, so I do think there is some scope there for some more work to be done, whether that's through universities and students unions working in partnership to look at the different ways—

[641] **Darren Millar:** So, it doesn't feature in any of the pilots that you've got active at the moment.

[642] **Ms Henry:** If I'm understanding this correctly, as part of the accreditation, the pilots need to be working through the partnership. We talk a lot about partnerships, which are between students unions and the universities. They would need to be working with their student services and also their GPs, so it's likely they will either have a GP on campus or a local GP as well, where I'm sure they'd—. I mean, are you talking about, kind of, brief intervention and things like that?

[643] **Darren Millar:** Yes, precisely; that is what I'm talking about.

[644] **Ms Henry:** So, I couldn't give you the picture across all the pilots, because we're, at the moment, auditing, but I'm sure that there are—

[645] **Darren Millar:** It's been part of the consideration—

[646] **Ms Henry:** But I wouldn't be an expert and be able to tell you exactly what it's like.

[647] **Darren Millar:** What's the timescale by which you'll have completed the evaluation of the pilots?

[648] **Ms Henry:** So, at the moment, we're currently auditing. So, that should finish by the end of April. In terms of being able to actually share, kind of, a full picture of the research, we're hoping that that should be done by June/July. I know that I circulated the baseline survey, and I think we'd probably be able to circulate some of the interim report findings as well, but not for wider circulation, if that was helpful.

[649] **Darren Millar:** In terms of the successful features from each pilot, you're hoping to expand and roll out then, I assume.

14:30

[650] **Ms Henry:** Yes. So, we'd always hoped that we'd get two years of a grant from the Home Office, and then be able to roll out nationally, and I don't know whether you've seen the material in the papers on that model's successful green impact programme, which works on pro-environmental sustainable behaviours. So, that initially was funded by a Department for Environment, Food and Rural Affairs grant for two years, and is now delivered in half of all universities. We're hoping that the same thing will happen with alcohol impact but, because of not getting a second-year grant, which is kind of unfortunate in that sense, we're going straight to our kind of self-funding model, so we will be charging institutions to be part of the programme. But we'd always hoped that we'd have another whole year to demonstrate impact, and I guess also, obviously, as you know, the academic year is a lot shorter, so when we talk of a year, we're probably talking about six months of having these things rolled out.

[651] **David Rees:** Obviously, the impact is actually with the Home Office, as you said. Do you have any discussions with the Welsh Government when you set them up?

[652] **Ms Henry:** No, we haven't at the moment. That would certainly be something we'd be very willing to do. I don't know whether we've mentioned there was some social norming work that was done in 2010 by NUS Wales as well, which kind of started to inform some of

the work that we're doing now. So, you know, there's a space for the Welsh Government to be leaders on this as well. We'd be really keen to roll it out nationally.

[653] **David Rees:** I've got a question in relation to: have you done any research into the type of groups of individuals? Obviously, some students will come to university and then get embroiled in this sort of culture, as such. Are there any particular vulnerable type of groups you've identified—somebody who's more vulnerable to fall into that category?

[654] **Ms Henry:** What I would say is that the central research that we're doing is obviously the types of questions that we're asking, and that type of information would come from that. So we've not only done quantitative research, we've had a baseline, a mid point and an end point survey, looking at a range of different impacts for the picture in that sense. We've also done qualitative interview, we've also done focus groups with students, we've also got students to fill in diary studies, where they've taken pictures of the alcohol they're consuming. Alongside that, we've also got an academic board that would be going back and doing that kind of localised research as well.

[655] **David Rees:** Okay. Do any other Members have questions? No. Thank you very much for your time and the evidence. It's been very helpful.

[656] **Mr Coole:** Thank you very much.

[657] **Ms Henry:** Thank you.

[658] **David Rees:** You will receive a transcript of the evidence. If there are any inaccuracies, please could you let us know as soon as possible? Thank you.

[659] We have our next panel about to come in. It will be the third panel session this afternoon. We'll have evidence from the police, the Association of Chief Police Officers and Her Majesty's Inspectorate of Prisons.

14:33

Papurau i'w Nodi
Papers to Note

[660] **David Rees:** Whilst we're waiting for the witnesses, I'll move to item 11 now. Are Members happy to note papers? That's the minutes of the meeting of 5 March; the correspondence from the Presiding Officer regarding the supplementary legislative consent motion, which was discussed on Tuesday of this week; and the correspondence from the Petitions Committee regarding support for safe nursing staff levels. Do we note those? Thank you very much.

[661] Just for information purposes, the minutes from 5 March will be amended to include details of the additional information Members agreed to request from local health boards on the Welsh Independent Healthcare Association. We had them last week, but it wasn't recorded in the minutes.

14:35

Ymchwiliad i Gamddefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 9
Inquiry into Alcohol and Substance Misuse: Evidence Session 9

[662] **David Rees:** Good afternoon. Thank you for coming along. Can I in advance thank

you for your written evidence we've received in relation to this inquiry this afternoon? Can I welcome Paul Roberts, who is a member of Her Majesty's Inspectorate of Prisons? Welcome back; we have met in a previous inquiry.

[663] **Mr Roberts:** It's nice to be back.

[664] **David Rees:** Inspector Nick McLain, Chief Inspector of Gwent Police, and we have Assistant Chief Constable Jon Stratford, representing the Association of Chief Police Officers.

[665] **Mr Stratford:** Yes, that's right.

[666] **David Rees:** As I said, thank you for the evidence. If it's okay with yourselves, we'll go straight into questioning. Gwyn Price.

[667] **Gwyn R. Price:** Good afternoon, everybody. Could you outline the treatment pathways available to alcohol and substance misusers on admission to prisons, and the resettlement afterwards?

[668] **Mr Roberts:** How long have I got? Okay. Well, thank you for the question. Typically, people coming into prison will first come from the court to a local jail, so, in the case of Wales, you're looking at Parc, Swansea or Cardiff. They will be assessed or screened by healthcare professionals and asked at that time if they have any drug or alcohol problems. If they say that they have, then they will be asked the nature of those problems. In the case of alcohol, they will be then screened using a screening tool called an AUDIT, which is an alcohol use disorders identification test. That will ask them a series of questions to find out the extent of their alcohol problem, and actually ascertain whether they are alcoholic or not. It will also seek to ascertain whether they're in alcohol withdrawal.

[669] As you probably know, alcohol withdrawal is a potentially life-threatening condition, because when someone withdraws from alcohol their brain can expand very rapidly. That can cause seizures and death, so they need to be medicated quite quickly. And, in Welsh prisons, the inspectorate found that that happens to a high standard, and, certainly, when I've inspected the Welsh prisons I've never found any problems with that medical treatment.

[670] Prisoners, if they do require alcohol detoxification, will be immediately prescribed relevant tranquilisers and other medication, and they will be taken on to, for example, a stabilisation unit, which is a wing where they will be properly looked after in that condition. If they're really severely in withdrawal, they may go to the prison hospital wing, if that exists.

[671] Shall I continue with alcohol, or take it all the way through?

[672] **Gwyn R. Price:** I was more concerned about—particularly in Gwent, and I represent Islwyn—the resettlement after. Because, in our opinion, and witnesses have shown it as well, there seems to be no back-up. Although the report says it's a very good service after they're released, there's a lot of people that disagree with that.

[673] **Mr Roberts:** Okay. Well, when we inspect a prison, we measure the extent to which the prison services have links with the community services, and we can really only go on what we're told in the evidence that's presented to us. Certainly, when we've inspected Welsh prisons, we've found there have been good links with community services—that they can link prisoners up with Alcoholics Anonymous and various other community-based interventions.

[674] The extent to which that is actually happening is difficult for us to measure. It's also difficult to measure from the prison side of the gate, if you like, the extent to which prisoners on release would avail themselves of those services, and that would be more for other services

to measure the take-up.

[675] **Gwyn R. Price:** Could I go on then to the other services from the police point of view, because you obviously know the circumstances up in the Islwyn area, and you know that it's not just one particular area? Do you think there are the establishments or suitable places to receive and help people coming out of prison?

[676] **Mr McLain:** I suppose that's a difficult question to answer on behalf of the police; we don't really—

[677] **David Rees:** I think we need to be careful we don't focus on a particular case, because obviously that case hasn't been issued yet, but, on a general principle, we're looking at this question of: are you aware of services, once people leave the prison sector, to support individuals or are there deficiencies there, in your view?

[678] **Mr McLain:** I think there are services available for those people, once they're released from prison. Certainly, we're seen to have an involvement, and we have teams of people who are involved in the management of the release of prisoners, particularly certain categories of prisoners, and they are always signposting agencies and different partnerships available to help those people out. So, I think there are support services there.

[679] **Mr Stratford:** What that would look like, in terms of our work—it would mainly be through what we would call our integrated offender management arrangements. They will vary across Wales—each force will have different arrangements. But good practice would mean that when people are released—they are on licence, so they're statutory, or, when they're released not on licence, they're non-statutory but they're still willing to engage with us—through what we call our IOM, integrated offender management arrangements, we would look to provide pathways out of crime, and they do tend to focus around drugs rehabilitation and alcohol rehabilitation. So, for us, that's the way that—. That's what services to those who are dependent upon alcohol would look like. Beyond that, we wouldn't really have a view, because it doesn't really fall within our—[*Inaudible.*]—remit.

[680] **David Rees:** Lynne.

[681] **Lynne Neagle:** Thanks, Chair. Can I ask the police, given the cuts that you've had to deal with in the last few years, do you feel that you've got sufficient capacity to deal with alcohol problems?

[682] **Mr Stratford:** Well, I'm not sure—. When you say, 'deal with alcohol problems', do you mean deal with the wider societal issues, such as the night-time economy, as opposed to what we were just talking about there, which was people that come into custody?

[683] **Lynne Neagle:** Yes. Dealing with the fallout on Friday night or—[*Inaudible.*]

[684] **Mr Stratford:** Policing is a business where supply will never meet demand. So, I guess the answer to that is that we will provide policing services in those areas up to the level of the capacity that we have available. I do want to make the point, though, that in all of the police services—certainly all of the ones in Wales that I know—all of our shift systems are geared around the need to double our strength on Friday and Saturday nights. So, actually, on Friday and Saturday nights, in order to deal with the issues that arise both within the night-time economy and within, you know, the population more generally, for example, the kind of rise we'll see in households around domestic violence, which we know is very often alcohol-related—. The sale of alcohol, actually, has that kind of draw upon our resources, and those are resources that are, then, not available for their neighbourhoods at other times.

[685] **Lynne Neagle:** Okay. Any comments?

[686] **Mr McLain:** [*Inaudible*.] There's a lot of proactive work undertaken as well, so it's not just the reactive stuff. There's proactive stuff we do in terms of licensing, and making sure that we get good relations with our licensees—that type of thing—that all helps on a Friday and Saturday night as well.

[687] **Lynne Neagle:** Okay. In relation to licensing, are there any changes that you'd like to see? Do you think local authorities could be working more in partnership with the police, or are you happy with the way, broadly, the framework works?

[688] **Mr McLain:** I have to say I can only speak for my own force, which is Gwent, and we've got a good framework there for licensing. We like to think we've got a good grip on our local premises. We don't have many problem pubs throughout the country, or nightclubs, and that is because, I think, we do have good systems, good relationships, and we work really closely with licensees. I think the system there is quite effective.

[689] **Lynne Neagle:** Okay. Thanks.

[690] **Mr Stratford:** I'll make the point I made earlier, about the huge draw that the licensing trade does make upon our resources. I've never really been able to get into the economics of that, in terms of the cost to public services—not just the police service, but also the health service—versus the tax take that actually comes from a vibrant night-time economy. It would be interesting to take a look at that. When you look at a kind of very—I'm not undermining what Nick said, because, absolutely, on a local level, we work closely with licensees and we work closely with local authority licensing departments, and, generally, that works pretty well. There is sometimes an issue with big business, so, for example, when a big pub chain wants to open up an establishment in one of our town or city centres, then sometimes you do get a sense that local authorities run shy of the kind of legal muscle that they could bring to any challenge there, so, there can be an issue around that sometimes. But I do question—I do question—how much the licensing industry actually costs society and how much it actually puts back into society. Now, let me be really clear—I'm not a member of a temperance society, and I enjoy the night-time economy as much as anyone else, but, actually, in other fields of policing activity, for example, football, where you have a private profit-making company that is making such a draw upon our resources, we do go for full-cost recovery. I do wonder to what extent the public purse is subsidising the cost of the licensing industry.

14:45

[691] **Lynne Neagle:** Okay. Thank you. Just finally, there was an announcement last week that the Welsh Government was making £500,000 available for operation Tarian. Have you got any comments on the likely impact that will have?

[692] **Mr Stratford:** I think it's very, very welcome. I worry that, in an age of austerity, if government—local or the Welsh Government—start to step away from drugs and alcohol rehabilitation programmes, that may well start to fuel crime again, because, certainly, from previous experience elsewhere, I've known that the best way to cut crime, particularly acquisitive crime, is to make sure that those who are drugs and alcohol dependant are in effective rehabilitation and aren't out there committing crime in order to fund their habits. So, it's very welcome and very important.

[693] **Lynne Neagle:** Thanks.

[694] **David Rees:** Okay. Alun.

[695] **Alun Davies:** Assistant Chief Constable, your statement on the impact of the night-time economy, shall we say, on your force and other forces is a shocking one—shocking. I don't think it's something that we can just walk away from. In terms of the structural way in which we manage that economy or that economic function, shall we say, you said that, on a local level, the licensing structures work reasonably well. I'm not sure how those two statements work in tandem, because, clearly, if the night-time economy is as dysfunctional as you suggest and creating a need for a policing intervention, then there is an issue in terms of how we're managing that economic function, and licensing is one of the key tools that we would use to do so. So, I'm not sure I quite understand how those two statements work together. From a policing point of view, is there more that the civil authorities should be doing in order to reduce the burden on both the force and, I would expect, on individual officers as well? I would have expected that it's a very stressful policing environment, that sort of environment, and I would have expected, as well, that you're not just deploying officers there in terms of numbers, but you're actually putting them in and exposing them to quite a difficult policing environment. Is there more that the public authorities could be doing to, first of all, reduce that impact on you and your force and, secondly, to help you manage it as it is?

[696] **Mr Stratford:** I'm not being mealy-mouthed when I say it's very difficult to say. When you look at the macro level, yes, it is very significant, isn't it? It just seems to be accepted that that's the way the system works at the current time. I can show you graphs of our demand profile. There are huge peaks on a Friday night and a Saturday night and, increasingly now, sometimes midweek, when you have, for example, students drinking in Cardiff. So, we know that alcohol is a great driver of demand upon us, both in terms of the visible night-time economy and also the kind of knock-on effects that happen within households and elsewhere. We know that, whenever we look at domestic abuse and domestic violence, alcohol is a great driver of that. So, at that macro level, we know that the way that our society uses alcohol drives a lot of demand upon not just the police service but also the health service.

[697] Having said that, at a local level, on a day-to-day level, our licensing arrangements work quite well in terms of controlling problem premises. It's difficult to put the kind of problems I've been talking about at the door of one or two premises. It's the industry as a whole that is actually placing that demand upon us.

[698] This is a personal view, and not one of my chief constable or colleagues, but I've often wondered whether there are systems where we can introduce more of what I would call a 'polluter pays' approach to this. There are some schemes around, such as late-night levies, and often there is a choice to be made between whether a local authority works within the community safety partnership to impose a late-night levy or whether they go down, for example, what is called a business improvement district, but that might just be an English construct, I'm not sure. But, the kind of money involved there ends up being quite small really. It would normally fund—for a local authority area—one or two posts, for example, to become a town-centre manager or similar. At the macro level, though, I do wonder whether we should be doing more to make the polluter pay.

[699] **Alun Davies:** I understand and I'm grateful to you for that. The numbers I have available to me from Gwent Police say that, of the 16,000 arrests in its area in 2013, only 5 per cent—800—were for being drunk and disorderly. I'm quite surprised by that, because, given what you've just said, I would have anticipated a policing response that would have led to a greater number of arrests.

[700] **Mr Stratford:** Do you want to answer that?

[701] **Mr McLain:** When you think, I suppose, across the country, that's quite a high level

of arrests, week in week out.

[702] **Alun Davies:** But given what has just been said about the impact on your whole policing structure—.

[703] **Mr McLain:** Don't forget, it's not just drunk people being arrested for being drunk and disorderly. They're also being arrested for public order offences, assaults, sexual offences, and domestic incidences. There's a whole range of offences that people are being arrested for. I'm sure that's concentrating there on—

[704] **Alun Davies:** On the single offences.

[705] **Mr McLain:** On a single offence. There's a wide variety, a wide range of offences.

[706] **Alun Davies:** Okay, I accept that. So, could you, perhaps, give us an indication, then, of the wider impact? Look at the arrest numbers, just to give us a sense of an impact on crime, on criminality. Is it possible—again, we'll use Gwent Police as the example since those are the numbers that we are dealing with—for Gwent to say to us, 'The night-time economy, largely alcohol driven, leads to 800 arrests for the crime of being drunk and disorderly; however, it leads to how many other arrests for however many other offences, whether it's criminal damage, violence, domestic violence, or whatever it happens to be'?

[707] **Mr Stratford:** Drink driving.

[708] **Alun Davies:** Yes. Drink driving, yes. So, is there a way of you providing us with the numbers, where your officers believe that—in making that arrest—alcohol was a key part of that particular offence?

[709] **Mr McLain:** I think, from a recording standpoint, that might be challenging. Data gathering is certainly not my field of expertise, and I'm just looking at the data I provided: 27 per cent of detainees last year were recorded as being under the influence of alcohol and drugs. But, again, that's just at the time of their arrest. Obviously, there are occasions when people commit offences when drunk, and we arrest them at a later date when they're sober. It does become challenging to find that level of data.

[710] **Alun Davies:** Okay. I'm interested just in—. You'd have the numbers of arrests and when they took place, so you'd know how many people were arrested between 9.00 p.m. on a Friday night and 6.00 a.m. on Saturday morning, so perhaps those sorts of numbers would be useful.

[711] **Mr Stratford:** I guess it's a proxy measure, but the best measure is to look at call demand and incident demand coming into our call centres, and how that peaks at times when the night-time economy's in progress. The night-time economy is part of the alcohol driver. Don't forget, there's a lot of off sales, a lot of people drinking at home and there's alcohol being consumed elsewhere. I'm not saying that this is all about the night-time economy; I'm saying it's all about alcohol.

[712] **Alun Davies:** Okay. In terms of the policing approach to this, for example, if you arrest a young man for, I don't know, criminal damage, for argument's sake—he's broken something, whatever—and your officers recognise that that person is drunk and is very drunk, what is the policing response to that? I presume that you would take that person into custody, if you want to make an arrest. How would you respond, both to the offence, but also to treating the condition that that person is experiencing?

[713] **Mr McLain:** Obviously, the person would come into custody, into one of our

custody centres. They'd be assessed by a custody sergeant as to their condition, so that we can make a risk assessment of the person firstly, because they're obviously in our care and control, then, and we need to look after them. There'd be an intervention in the custody suite if necessary; they'd probably see the custody nurse or the force medical examiner, whichever's available. Ordinarily, if the situation wasn't too serious, if they weren't too medically difficult, i.e. if they were able to be held in a cell, we'd keep them overnight until they're sober, deal with them the following morning—

[714] **Alun Davies:** Sleep it off.

[715] **Mr McLain:** Interview, followed by a charge or not—some sort of outcome or disposal for the offence that they're in. We would then have the potential to refer them on to other agencies, so we've certainly got those links with other partners. So, whether there'll be an intervention that we could, leading down that path—. But those facilities are there.

[716] **Alun Davies:** That's what interests me—

[717] **Mr Stratford:** Can I just clarify that point? Sorry to interrupt you there, but I think it's important here to make the distinction between drugs and alcohol. Coming back to the integrated offender management arrangements I spoke about earlier, it's relatively easy—relatively easy—to identify the small cohort of what we call problematic drug users. So, they're people who are out there committing crimes, so therefore being arrested by us, because of their drug taking. Within a city like Cardiff, that would probably number 300 or 400. That's an estimate, but that's the kind of range of people you're talking about. At any one time, there might be 20 or 30 who have, as we would say, fallen off the wagon. They've become regular offenders. They're committing crime on a daily basis in order to fund their drugs habit. One of the ways in which we've driven down serious acquisitive crime is by becoming particularly effective at targeting them. It's a relatively small cohort for problematic drug taking. It's a much larger cohort for alcohol. The people who are coming through our custody suite on a Saturday night are not the same people that we arrested the month before and the month before and the month before, because a much larger section of the community are periodic problematic alcohol users, and—[*Inaudible*.] Why do I make that point? It's because, unless somebody was a prolific offender, they probably wouldn't be routed into some form of rehabilitation for their alcohol problem.

[718] **Alun Davies:** That's the point I was coming to, because it would appear—. If, you know, this young guy, say Dai Jones, had a bad night and did something stupid, got arrested and slept it off, that's one thing. But, if he's back the following week or he's back two weeks later and he's back next month and then he's back again, he clearly isn't just having one bad night. He's got difficulties in terms of his relationship with, for argument's sake, alcohol. At what point would your officers have a protocol that says, 'This guy isn't just a guy who's having a bad night and being a bit of an idiot. This guy has actually got alcohol problems that need to be addressed'?

[719] **Mr McLain:** For me, it's probably like Mr Stratford said—

[720] **Alun Davies:** What protocols do you have in place to determine the help—

[721] **Mr McLain:** When a person keeps coming to our notice, that person is flagged up on our intelligence systems, and they become a person of note for the police. If their offending behaviour becomes a concern to us then we will score them under, as the ACC said, the integrated offender management unit protocol. Once they're in the IOMU system, that's the time when we get other agencies involved and start speaking to health and housing. That's when you get the more holistic approach to managing their offending, managing their behaviour, managing their alcoholism or drug abuse.

[722] **Alun Davies:** How often does that actually happen? If, for example, in Newport you're dealing with, I would have thought—. It's a long time since I've been in Newport in the evening, but I would anticipate that you're dealing with a relatively large number of people in the city centre there on a Friday and Saturday night. I presume that there is a group of people that you would recognise—there are people where you think, 'Oh, here it goes again'. At what point, and under what protocol, would your officers actually say, 'This guy has got problems with alcohol and the criminality is a symptom of that and we need to address the causes'?

[723] **Mr Stratford:** If they become effectively what we'd classify as a prolific offender, they would go into our IOM cohort, but I have to say that, from experience, quite a small proportion of the cohort—a very small proportion—are alcohol dependent. Nearly all of our prolific offenders within IOM are drugs dependent. Having said that, there is a variety of other—. It would vary depending upon which custody suite you went into, but, in some areas, there are diversion schemes. For example, in Cardiff, we have a very successful—very successful is overstating it—a very promising diversion scheme for women who are arrested. If their issues are to do with alcohol, then the scheme would be made available to them. We have healthcare in all of our custody suites. I would hope that if that person was coming into the same custody suite, which in, for example, Newport, would be likely, after a few visits they would be recognised as such and, through healthcare, some sort of help would be put in their direction. That's not really our experience though. Our experience of your standard person who gets arrested for an alcohol-related offence on a Friday or Saturday night, or any night of the week, is that it tends to be a one-off.

[724] **Alun Davies:** So, it's drugs—

[725] **Mr Stratford:** Drugs is the big driver for serious acquisitive crime, yes. The general rule of thumb in policing is that drugs drive acquisitive crime—robbery, burglary and car crime—and alcohol drives violent crime. That's grossly simplistic, but it's a general rule of thumb. I would include sexual offences in violent crime as well.

15:00

[726] **Alun Davies:** Okay.

[727] **David Rees:** Darren?

[728] **Darren Millar:** Yes. I just wanted to ask about the services available to prisoners, if I can, who have substance misuse problems. Your evidence is very alarming, in a sense, in that when you look at the availability of drugs, in particular, in prisons—and new psychoactive substances, as this committee has done recently—it seems that prisoners can generally have easy access to these things, particularly in some of the Welsh prisons, which appear to have easier access than many elsewhere in the UK. I know that, as an inspectorate, you inspect the availability of services, and it appears that in some Welsh prisons not everybody is being offered access to a service; not everyone is getting a successful outcome from their service; and it's still too easy to get access to harmful substances. So, what, as an inspectorate, are you doing about that; and how does the Welsh Government respond to your inspection reports, given that it is responsible for prison healthcare now in Wales?

[729] **Mr Roberts:** Yes. What we do about it is make recommendations for improvement.

[730] **Darren Millar:** Yes.

[731] **Mr Roberts:** The sort of recommendations that we've made is that there should be a

much better level of access to the kind of programmes that we're talking about. If we talk about Swansea prison, which is the most recently inspected, and actually really is probably the most alarming in terms of the lack of services, we can roughly say that a majority of the problems through the lack of delivery of services was down to short-staffing. The way that the programmes have been put together is that the recovery unit in Swansea prison was staffed by specially trained prison officers, but with all of the shortages of staff in other prisons, many of those officers were then put on what they call detached duty and transferred to other prisons to fill gaps, which meant they effectively had to shut down that programme on that wing. So, unless the Welsh Government can ring-fence officers to do specific jobs in prisons, you're always going to run the risk of having those programmes interrupted.

[732] **Darren Millar:** So, how does it work? Just explain this to me. So, the Welsh Government have devolved responsibility for providing prisoner healthcare—

[733] **Mr Roberts:** Yes.

[734] **Darren Millar:** —including access to substance misuse services. So, they make cash available to the prison service. They commission those services, effectively, from within the prison service itself. So, how on earth can the people in charge of the prison divert those resources elsewhere, into a non-devolved part of the function of the prison service?

[735] **Mr Roberts:** I think it's just down to staffing levels. You know, when officers have been trained to deliver programmes and then those officers are needed elsewhere, they will be sent elsewhere.

[736] **Darren Millar:** So, Healthcare Inspectorate Wales would have some responsibility as well, I presume, for monitoring the effectiveness of the resource that the Welsh Government is making available. How is the Welsh Government holding to account the prison service for the use of its resources? Does it, or doesn't it?

[737] **Mr Roberts:** That's not a question, I'm afraid, that I can answer.

[738] **Darren Millar:** But they don't work with you as an inspectorate, for example?

[739] **Mr Roberts:** Not directly. Healthcare in Wales used to work with us, but I think, again, they're short-staffed and we haven't seen them on our inspections of late.

[740] **Darren Millar:** So, in terms of feedback from your inspections to the Welsh Government on aspects of the service that you inspect, which they fund, there's no formal relationship—there's no formal requirement for you to share—[*Inaudible.*]—with the Welsh Government if there's a health issue that—

[741] **Mr Roberts:** Our reports are published and are made publicly available.

[742] **Darren Millar:** Yes, but that's not the same as—

[743] **Mr Roberts:** NOMS, the National Offender Management Service, will then pick up the recommendations, and then any other transmission of responsibility.

[744] **Darren Millar:** But that's not the same. Frankly, saying it's publicly available, therefore everybody's got access, is not quite the same as saying, 'Look, we've got serious concerns about this aspect of the delivery of the substance misuse services in Swansea prison, Cardiff prison, Parc prison, or whichever prison we want to talk about', because they all appear to be worse than their comparators elsewhere.

[745] **Mr Roberts:** Yes.

[746] **Darren Millar:** Surely, there ought to be some formal mechanism where you're required somehow, or the Welsh Government is required, to pay some attention to the outcome of your inspections to see if there's anything they need to do to plug a gap in a service, or make sure it's being delivered effectively?

[747] **Mr Roberts:** As I understand it, there is currently within statute no formal requirement to respond to our recommendations; they are recommendations rather than directives.

[748] **Darren Millar:** You'd welcome that, though, would you? You'd welcome some more formal mechanism to ensure that the Welsh Government is alerted to an issue, so that it can be addressed.

[749] **Mr Roberts:** That would be a good thing, I'm sure, in my view, yes.

[750] **Darren Millar:** Okay.

[751] **David Rees:** Can I expand on one point? You mentioned that HIW no longer accompany you. Did they used to accompany you when you did inspections?

[752] **Mr Roberts:** Yes, they did, and we used to have meetings with them, but I think, again, resourcing has been an issue for them.

[753] **Darren Millar:** Because for many people, prison is a place where they are at least able to get access to a rehab service that perhaps they had some difficulty accessing on the outside, and they then went to be able to stay clean. But if they're not even being offered services—. It looks like less than half the prison population in Cardiff, Parc and Swansea prisons are even being offered access to a service, even when they have a problem, which just seems remarkable. But Healthcare Inspectorate Wales used to accompany you, but no longer do.

[754] **Mr Roberts:** That's my understanding, yes.

[755] **David Rees:** We've got that clear; thank you. Any other questions? Lindsay.

[756] **Lindsay Whittle:** Just two quick questions, one to Her Majesty's Inspectorate of Prisons. It's a simple question: how on earth are alcohol and substances getting into the prisons, and are you doing enough to stop that? And the next question is to the representatives of the police authorities.

[757] **David Rees:** Let's deal with the first question.

[758] **Lindsay Whittle:** Okay; thank you.

[759] **Mr Roberts:** Okay. It's relatively rare in a category B or A prison for alcohol to get in, and in a category C prison it's still pretty rare. In a category D prison where prisoners are released on a temporary licence to go out and work in the community and it's an open prison like Prescoed, then they will bring it in or throw it over the fence and retrieve it later, because they have relatively easy access around the grounds. So, in terms of prisons like Parc, Swansea, Cardiff and Usk, we're talking about people that may well brew the alcohol within their cell, and that is what it's known as 'illicitly brewed alcohol' or, in prison language, 'hooch'. So, it's not a case of it being brought in—it's a case of it being produced from within in those cases.

[760] **Lindsay Whittle:** Are there no such things as cell searches?

[761] **Mr Roberts:** There are no such things as random cell searches any more. Again, it's a resourcing issue within the whole of the England and Wales prison service. So, the cell searching will be done on suspicion. There are a number of prison dogs that are trained to smell alcohol, and obviously prison officers have noses and they will be able to smell because, believe me, when it's being brewed it's pretty darn smelly. So, they will respond in that way. But prisoners are very, very resourceful and they will do many things to contain it and do everything they can to make sure it isn't detected.

[762] **Lindsay Whittle:** Okay. Thank you for that. And the question to the police officers present: a lot of the drug offences—. I can't believe that, in north Wales, 5 per cent of arrests are for drug offences, yet in Dyfed-Powys, 20 per cent are for drug offences. Whenever I have been at public meetings, in particular involving young people, if someone mentions the legalisation of cannabis there are huge rounds of applause and cheering. I'm not advocating the legalisation of cannabis, because I'm from a bus-pass generation and I've never used any illicit drugs. But do you think there's a case for allowing cannabis to be used, or not, because it would release a lot of resources for the police to concentrate on the more serious crimes? That is the argument, I'm told, but I'm not advocating that.

[763] **David Rees:** That's partly beyond the scope, because the legalisation of those drugs is the UK's responsibility, not the Welsh Government's responsibility.

[764] **Mr Stratford:** The position of the former Association of Chief Police Officers is not to be drawn into debate around whether it should be legalised or not. The strapline we would take there would be that we are law enforcers, not law makers. What we do is apply the law thoughtfully. We certainly wouldn't advocate an attempt to arrest and prosecute our way out of a drugs problem. But where we could use the law to actually deal with a drugs problem, then we would use the law sensitively and thoughtfully.

[765] **Lindsay Whittle:** Okay. That's a good answer. Thank you very much.

[766] **David Rees:** I'll take the privilege of the last question and it's to the police, in a sense. Are we seeing a growing change in the complexities of alcohol and substance misuse, in the combinations of both? Are we seeing more polysubstance misuse in one sense, particularly on a Friday and Saturday night? We talk about a night-time economy, but are we also seeing a night-time economy with what some people call—and I wouldn't call it—recreational usage of drugs, as well? As a combination, are we seeing more complexities?

[767] **Mr Stratford:** You're closer than me.

[768] **Mr McLain:** I don't think it's becoming more complex. We all know about new and emerging drugs—new psychoactive substances and those types of things—and there're always new drugs coming on the market. It's a complex, fluid marketplace, I suppose. I don't know whether it's becoming more complex, or if it's always been complex. Ultimately, it's the same type of problems that you're dealing with, no matter which substances have been taken. So, I wouldn't say it's more complex.

[769] **David Rees:** But in the sense of your ability to deal with those individuals, is that more difficult if they are on multiple substances?

[770] **Mr Stratford:** If we're talking about night-time economy and we've arrested somebody from within a night-time economy, it's difficult to tell, there and then, exactly what is the cause of the problem. Our officers will regularly experience people who are very

difficult to deal with. There is a phenomenon where people—. There's something to do with the consumption of cocaine combined with alcohol that can lead to people being very violent and it's not unusual for officers to struggle to detain some people who are in that condition. But I'm not aware of any actual research, or I'm not able to actually put any numbers around just how much more complex that situation is becoming, other than to say that we know that the night-time economy, and alcohol in general, is a huge driver of demand.

[771] **David Rees:** Okay. If no other Members have any other questions, can I thank you all for this afternoon's evidence? It's been very helpful, thank you very much for coming. You will receive a copy of the transcript for any factual inaccuracies you may identify. If you do spot any, please let us know as quickly as possible. So, thank you very much for your evidence; you've been very helpful.

[772] Just to remind Members, we have done item 11 on the agenda, but I have been reminded of one point. On the letter from the Presiding Officer regarding the LCM, do you wish for me to write on behalf of the committee to the PO expressing our disappointment at the short notice we received? Therefore, we didn't have an opportunity, on this occasion, to actually evaluate and scrutinise that LCM.

[773] **Darren Millar:** We all registered our disappointment in the Chamber, didn't we? I think every group registered their disappointment at the timeline, in being able to consider it, didn't we?

[774] **Lynne Neagle:** That's right.

[775] **Darren Millar:** We did, didn't we? I think we should—. It's a tricky one, isn't it?

[776] **David Rees:** It is. Okay. I just wanted to check with you.

[777] Can I remind you, therefore, that we agreed earlier that the remainder of this afternoon's session will be in private and the first session on Wednesday next week will also be in private? So, we now go into private session.

Daeth rhan gyhoeddus y cyfarfod i ben am 15:13.
The public part of the meeting ended at 15:13.