



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

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

Dydd Iau, 17 Mehefin 2015
Thursday, 17 June 2015

Cynnwys
Contents

[Cyflwyniad, Ymddiheuriadau a Dirprwyon](#)
[Introductions, Apologies and Substitutions](#)

[Sesiwn Graffu Gyffredinol a Sesiwn Graffu Ariannol gyda'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Iechyd](#)
[General and Financial Scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health](#)

[Cefnogaeth i'r Bil Lefelau Diogel Staff Nyrsio \(Cymru\): Cynnig i Gau'r Ddeiseb Support for Safe Nurse Staffing Levels \(Wales\) Bill: Proposal to Close the Petition](#)

[Papurau i'w Nodi](#)
[Papers to Note](#)

[Cynnig o dan Reol Sefydlog 17.42\(vi\) i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod ac o'r Cyfarfod ar 25 Mehefin](#)
[Motion under Standing Order 17.42\(vi\) to Resolve to Exclude the Public from the Remainder of the Meeting and from the Meeting on 25 June](#)

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynnddi 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

Alun Davies	Llafur Labour
John Griffiths	Llafur Labour
Mike Hedges	Llafur (yn dirprwyo ar ran Lynne Neagle) Labour (substitute for Lynne Neagle)
Altaf Hussain	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Gwyn R. Price	Llafur Labour
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

Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Minister for Health and Social Services)
Vaughan Gething	Aelod Cynulliad, Llafur (y Dirprwy Weinidog Iechyd) Assembly Member, Labour (the Deputy Minister for Health)
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol a Phrif Weithredwr GIG Cymru Director General for Health and Social Services and NHS Wales Chief Executive
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio, Llywodraeth Cymru Director of Social Services and Integration, Welsh Government
Dr Ruth Hussey	Prif Swyddog Meddygol Chief Medical Officer
Martin Sollis	Cyfarwyddwr Cyllid, Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director of Finance, Health and Social Services, Welsh Government

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

Martin Jennings	Y Gwasanaeth Ymchwil
	Research Service
Zoe Kelland	Dirprwy Glerc
	Deputy Clerk
Llinos Madeley	Clerc
	Clerk

*Dechreuodd rhan gyhoeddus y cyfarfod am 10:04.
The public part of the meeting began at 10:04.*

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Can I welcome Members and the public to this morning's meeting of the Health and Social Care Committee? Can I remind everyone that, in fact, the meeting is bilingual under the policy of the National Assembly? If you wish to have translation from Welsh to English, the headphones are available. It's on channel 1. If you need amplification from the headphones, that's channel 2. Everyone is completely free to speak in either of the languages.

[2] I remind people to turn their mobile phones off, please, or any other electronic equipment that may interfere with the broadcasting. I'll check mine. In the event of a fire alarm, there is no scheduled alarm this morning, so can you please be aware that, if one does go off, you should follow the directions of the ushers? We've received apologies from Lynne Neagle. Can I welcome Mike Hedges, who will be substituting on behalf of Lynne?

10:05

Sesiwn Graffu Gyffredinol a Sesiwn Graffu Ariannol gyda'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Iechyd General and Financial Scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health

[3] **David Rees:** This morning's session, moving on, we have the general and financial scrutiny of the Minister and the Deputy Minister. Can I welcome the Minister for Health and Social Services, Mark Drakeford, and the Deputy Minister for Health, Vaughan Gething? Can I thank you for the written papers we've received from you in preparation for today's session? Minister, do you want to introduce the officials that you have with you today?

[4] **The Minister for Health and Social Services (Mark Drakeford):** Thank you, Chair. So, Dr Andrew Goodall, who is the chief executive of the NHS in Wales and director general of my department; Dr Ruth Hussey, Chief Medical Officer; and Martin Sollis, who is head of the budget division in our department. And Albert as well. I'm sorry, Albert. He's so far away at the end. Albert Heaney, who leads on social services.

[5] **David Rees:** Thank you, Minister. Because of the tight timescale, we will move straight into questioning, if that's okay with you. Gwyn Price has the first question.

[6] **Gwyn R. Price:** Yes. Good morning, everybody. Minister, funding for the winter pressures was provided to those health boards that were delivering their approved plans. Did any health boards not receive any of this funding?

[7] **Mark Drakeford:** No, Chair; all health boards in Wales received a share of the £40 million that was made available for winter pressures.

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

[9] **David Rees:** Altaf?

[10] **Altaf Hussain:** Thank you very much. Just to ask you, Minister, every year we have a winter. They have been going on since we have, really, been living on the planet. What have we learned over these 14 years? Because every year this is a problem. Every year we are putting the money into it, and every year, say, for instance, these health boards who had qualified for getting this money—. Have we learnt anything from them? What have they put in? Why didn't other health boards take that up?

[11] **Mark Drakeford:** Thank you, Chair. I think that's a really interesting question. I think there are lots of things that we have learnt over the years in relation to winter pressures. One of the things that we learn is that the past is not always the best predictor of the future. So, even when you do learn what has happened, it doesn't necessarily prepare you for everything that you will face in the following winter. Members may remember that Public Health Wales did a piece of analysis of pressures in the Welsh NHS over the winter period. They isolated a series of different factors that they said could explain the demand that comes through the door of a district general hospital in that period. They say, for example, that demography definitely does matter. An ageing population does mean that frailer, older people are coming through the door. The average age in the Cardiff accident and emergency department over the last winter was 86 or 87 years old. But it's not just age; it's also complexity: that the switch in the way that older people, in particular, live their lives—less likely to be in residential accommodation, more likely to be living at home with complex packages of care around them. So, when people do come into hospital, their needs are often complex and take a while to respond to.

[12] But, weather does matter. We know that when the temperature falls, admissions into hospitals go up. Poverty mattered as well. In an age of austerity, there were people coming into the health service because it's the only service that's available every single day of the year, every hour of the day. We can learn lots from that to prepare for those things. The intermediate care fund that we made available last year, and are going to make available again, to a lesser extent, in the current financial year, helped to provide lots of services to meet those demands.

[13] Are there other things we know? Additional capacity over the winter is important, and that we may not always have worked out the nature and the number of the additional capacity that we need.

[14] **Altaf Hussain:** Can I make a small point on that? Say, for instance, when there were winter pressures this year, a lot of patients came through the A&E department. Now, this money, I would have thought, would have gone towards something else because when there is a roadblock, what do we do? We have a detour. We could have another door open for those elderly patients—flu sufferers—and that money would have been invested in those so that they could go directly into the medical departments, rather than going and blocking A&E with ambulances everywhere. That's No.1.

[15] No. 2 is the same thing, but about mental health this time. They were coming in and waiting in the A&E department for hours and hours and a little money could have helped us: we could put it into mental health services directly and those patients could have gone directly to the departments, rather than waiting for so long.

[16] **Mark Drakeford:** Chair, I think both of those are really important and valuable points. We know that there are some parts of the system in Wales where the first point is

exactly what happens. But you have senior clinicians at the front door, when someone comes in, who clearly doesn't need to go through an A&E department, but could be admitted directly to the wards; that's what they do. The Royal Gwent is an example of where that was done successfully this winter.

[17] On the mental health side, part of the extra money that I've been able to announce in the last couple of weeks for adult mental health services will mean that, in Wales, in the coming winter, we will have, at the front door of all our district general hospitals, a specialist mental health service of the sort that we've had in Cwm Taf over the last winter, because it does exactly what Altaf Hussain suggests: that, by identifying those people right at the start of their journey, sometimes you can avoid admission altogether, sometimes, you can reduce the length of stay, and you certainly get the person to the right part of the system much more quickly, rather than them simply being in an accident and emergency department where, sometimes, their physical needs mask the fact that they also have a mental health condition that needs attention.

[18] **David Rees:** Elin, on this point.

[19] **Elin Jones:** Yes. Can I just return to the issue of funding the winter pressures? You've confirmed to Gwyn Price that all health boards did receive an allocation, but, just to clarify that allocation, you've outlined in paragraph 8 of your paper that health board winter pressures were issued £6.8 million, the total allocated to NHS organisations—I'm not sure who these NHS organisations are; they're different to health boards—was £21.6 million, and then funding held back for central contingency was £18.4 million. Would you like to describe to us how that allocation was split, per health board? I'm assuming the majority of the £40 million still went to health boards other than what obviously went to the ambulance trust. And then, on what basis do you make the allocation to those health boards? How do they justify to you what exactly their demands for funding winter pressures are?

[20] **Mark Drakeford:** Chair, I'm happy to make available a table to Members that shows the breakdown of the information you have in paragraph 8 at a health board level, so that you can see how that was done. There were a number of broad categories that we used in allocating that money. There were some health boards that were able to demonstrate that unscheduled care was driving additional costs to them as part of the winter. Where they were able to demonstrate that to us, we drew down money for them to cover those additional costs. There were health boards that were able to demonstrate that the impact of additional winter pressures had had an impact on their ability to provide elective planned care, and, where they were able to recover some of that lost ground with additional funding from us, we provided additional funding for them to do that. And then you've seen the money that went to WAST, as well. But I'm happy to provide a breakdown against those categories, against each health board.

[21] **Elin Jones:** So, this allocation was per application by the health board, to an extent, and you then assessed it on the basis of the criteria you'd set. It wasn't related to population; it wasn't related to Townsend, or any other formula that you usually use with the health boards.

[22] **Mark Drakeford:** It was to respond to winter pressures, and health boards, therefore, had to demonstrate to us what the financial impact of those winter pressures had been, and, where we were satisfied that they were able to do that, then we were able to use some of that money to help them.

[23] **Elin Jones:** And, just quickly, when was it allocated to them, then? Was it in looking back at what winter had just been like and the actual spend, or was it in advance?

[24] **Mr Sollis:** It was looking—. Some was prospective in terms of estimates of elective activity they could recover and we have been checking that in terms of the actual delivery. Some of it was in relation to costs that they'd already started to incur, and we've monitored that and have again got confirmation and assurances that those costs were incurred in terms of winter pressures. So, some of it was retrospective, some of it was in relation to estimates of things they could recover and some of it was in relation to things like the WAST, in relation to emergency care for the Welsh ambulance service.

10:15

[25] **David Rees:** Can I take that a little bit further? Clearly, my own health board, for example, did suffer in terms of the electives as a consequence of the pressures they faced during the winter, and many operations were cancelled during that time because of that. It went up until, basically, April. So, are we therefore talking about funding being available for the next financial year to address some of the winter pressures that they faced in a previous financial year?

[26] **Mark Drakeford:** No, this was money available in the last financial year. It, therefore, had to be useable in the last financial year. There's no carryover of that money into the current financial year.

[27] **David Rees:** Okay. Mike.

[28] **Mike Hedges:** We always talk about winter pressures as if they're solely for hospitals, and for the last quarter of an hour we've talked solely about hospitals. Can I move on to other areas that come under you? One is the primary and secondary split, and the other one is social care. My first question is: surely, money spent on social care and primary care would actually reduce the number of emergency admissions? What is being done within the health service to try to get that to happen? People are ending up in hospital because that's the only place they can go.

[29] **Mark Drakeford:** Well, I don't disagree with any of that. We have to re-engineer the system so that our primary and social care components are able to absorb more of the pressure. Otherwise, it defaults to the hospital door. What are we doing? Well, in this financial year, we are using £40 million of a very small amount of new money that we are able to deploy directly in primary care in order to try and bolster the ability of primary care to provide services to the public, including services that would have an impact on presentations at hospital.

[30] I referred earlier to the impact of the intermediate care fund over last winter, which I think was genuine and real: £50 million was available in the last financial year; £15 million of that capital and £35 million of it revenue. I think that is a considerable tribute to the actions of our local authorities, health boards and the third sector, in particular, in being able to put that money to very good use very quickly. So, we will have spent almost the whole of it, despite the fact that it was in-year money, and people had to get their plans there very quickly.

[31] This year, we will provide £20 million in revenue as a follow-on to the intermediate care fund; £17.5 million of that has gone out to the planning fora that used the money in the last financial year to allow them to go on funding those schemes that they knew were most successful—especially those schemes that were most successful in being able to divert people from hospitals. So, they've got the evidence now. Inevitably, in the first round, these were prospective plans; these were ideas they hoped would work. Now they know the ones that really did work, and we will provide £17.5 million to whatever they are able to contribute to build on those successes; £2.5 million of it is being held back because I am very keen, where there is a scheme that—in Hywel Dda, for example—can demonstrate its success, that we

incentivise other parts of our health service to take that idea and use it in their area, and to do that right across Wales. I am going to use £2.5 million to help persuade the whole system to adopt the things that we know have worked in part of it.

[32] **Mike Hedges:** If I can move on to the primary and secondary care question, shall I ask that now? Another question I've got on primary and secondary care: we know that there was £63.8 million brokerage and overspend last year. What was the split between primary and secondary care of that overspend? I ask this because I have serious concerns that, since you created health boards—since health boards were created—primary care has been a massive loser against secondary care. As MPs spend most of their time talking about hospitals and forgetting about primary care, it might be inevitable, but I really do care about giving greater support to primary care.

[33] **Mark Drakeford:** I'll ask, probably, Martin if he knows the answer to the specific question, but let me just say that I entirely agree with the point that Mike Hedges is making. We've had an ambition in Wales, since the beginning of the Assembly, really, to have a primary-care-led health service in Wales, and it turns out to be very, very difficult to engineer, because the secondary care sector has such a draw on what the public thinks is important in the health service. It's always easy to mount a campaign for spending in hospitals, but much more difficult to do it in primary care. We have to do two things to make it happen, and I feel very determined we will make another major effort on it. One is we've got to push stuff out of secondary care; we've got to persuade our health boards to identify services that can be moved and then to push them out, but we need pull as well. We need GPs, in their new clusters, willing to use the money we are giving them directly to provide services at community level that previously would have been held in hospitals. Where it works—as I saw recently, when I went with Kirsty Williams to Brecon and saw primary care clinicians doing things that were absolutely demonstrably providing services that previously people would have had to go to hospital for—you see what a fantastic story it is. But a mixture of push and pull, I think, will help us to try and do something that we've had as an ambition, and that other places have had as an ambition too, and everywhere turns out to be a real struggle to translate into activity.

[34] **David Rees:** Is Martin Sollis able to give us a breakdown of the specifics?

[35] **Mr Sollis:** I think I'm going to have to write in terms of the general make-up, because I know that we produce these figures. Just since 2003, I know that there's been increases in general practice—it's increased by £147 million, rising to £322 million, to £476 million in 2013-14. So, there has been—

[36] **Elin Jones:** What's that as a proportion?

[37] **Mr Sollis:** They are the figures I haven't got, and I need to provide that to you.

[38] **Mike Hedges:** The GPs show it as a decreasing proportion of the money available, with a higher proportion going into secondary care.

[39] **David Rees:** If you could write and provide us with details it would be really appreciated.

[40] **Mr Sollis:** I will do.

[41] **David Rees:** Okay. I want to move on to the next item. Lindsay.

[42] **Lindsay Whittle:** Thank you, Chair. Good morning, Minister, and, of course, all your fellow workers. I wanted to talk about preventative health investment. It leads quite

nicely on from Mike Hedges's questions. You've provided us with evidence of the primary, secondary and tertiary prevention schemes—quite a lengthy list and lots of money being spent. I like the life-changing events that are being pushed by the health department and, of course, the screening, but how do you target the resources and evaluate whether we're getting value for money for all of these schemes, because, quite simply, if we're just pouring money down a black hole, then are we wasting our money? This is the important thing. It's money that we don't have, and we need to know how successful it is. Then I'd like to come on to a question about specialist nurses in that particular scheme, please.

[43] **Mark Drakeford:** Okay, thank you, Chair. If I just begin, then I'll probably ask Dr Hussey to address the more general point. Just to say that, if we're serious about primary care, then we have to be serious about preventative care too, and we have to persuade the system to move the dial right across what we do in health and social care to try and prevent those problems that need never have happened. Now, it's a big mantra of mine when I'm talking in front of audiences that, if we want the health service of the future to be there when we need it, for things that could happen to any one of us and over which we have no control, then we all have to do more to make sure that those harms that need never have happened can be avoided, and that's what the preventative agenda is all about.

[44] The largest sum of money is the one that Lindsay mentioned in terms of immunisations, and immunisations are very important to us. They clearly directly prevent things that are preventable, but they operate in a way that many other things fail to. It has a direct impact on health inequalities, because it has its biggest impact amongst those people whose health is the most fragile. But the system we have for agreeing new forms of immunisation is very well established; it's very scientifically driven. The joint committee on vaccination and immunisation, which is a UK committee, provides advice; it provides advice on both clinical and cost effectiveness. So, Members here will know that we've already announced that we will introduce a new meningitis B vaccination in Wales from September. It's a new thing completely. The JCVI was satisfied on the clinical effectiveness of the vaccine some time ago, but it took quite a large number of months of negotiation with the supplier of the vaccine before it was also thought to be cost-effective. Then those discussions were concluded at the end of March, and now we will introduce it. But, it's really built into the way that the system operates that the financial efficiency of any new vaccine has to be demonstrated alongside its clinical effectiveness. More generally, I'll ask Ruth to pick up some of the points that Lindsay raised.

[45] **Dr Hussey:** Just to emphasise the practical consequences of the vaccination example, we recently introduced a rotavirus vaccine for children, and that's already showing an impact in terms of reduced infections, but also reduced GP consultations related to rotavirus. So, it's a very practical manifestation that even when the evidence is strong and we invest in it, you can actually track it through and start to see the impact as well.

[46] In terms of the wider question about how we look at evidence, critically and regularly we have to look at both new science that's coming along suggesting that either what we're doing currently needs to be changed, or the new things that are possible that have come through appraisal. So, we've got a number of UK-wide committees that we take advice from; vaccination is one and screening is another one where we work regularly with the UK-wide committee to look at new evidence and new science that's coming through.

[47] Again, at a local level, we have a history, actually, of developing new ideas and new schemes and then testing them. There's an example of a smoking prevention programme in schools that was developed and tested in Wales, and shown to have an impact and therefore used in Wales. So, if we have new ideas and innovations, we're not holding back because there's no evidence but testing them properly and being willing to say, 'Yes, we roll them out' or 'No, we don't because they haven't shown the impact we hoped for', and I think you

have to keep testing.

[48] **David Rees:** Lindsay, you had one last question on this.

[49] **Lindsay Whittle:** These are illnesses that hopefully we can try and prevent, but a lot of people out there have illnesses through no fault of their own. During the four and a bit years I've been here, I've met lots of charities that tell me of the excellent work that specialist nurses do across Wales; I'm not going to name any of them because there are too many of them to name.

[50] **David Rees:** And we haven't got the time.

[51] **Lindsay Whittle:** And we haven't got the time. But, the service across Wales in some health boards is superb, but in others not so good, and we need to get that across the whole of Wales. Have you thought of a scheme of invest-to-save, so that if a particular specialist nurse in one health board has too many patients, there may be more specialist nurses across the whole of Wales, because each charitable organisation tells me that they can save us money in the long term?

[52] **Mark Drakeford:** Chair, I'm very keen to increase the number of specialist nurses in Wales. The £40 million we're investing in primary care this year—I hope to be able to make an announcement on the specifics of that very shortly—I think will show that there are places where we're going to be able to use that investment for specialist nurse purposes. The £18 million that we are investing in non-medical professional education in Wales this year has some specialist nurse components in it. It's absolutely important to us in the future of primary care, because the future of primary care in Wales will rest, I firmly believe, on a wider range of professional contributions to primary care, bolstering the GP service that we are able to provide. And the role of specialist nurses in primary care will be very important indeed in sustaining the primary care service in the future.

[53] So, I haven't thought of the specific way that Lindsay has mentioned this morning, but we'll certainly take that away and think about it. But, the general point about the fact that there are things that specialist nurses are able to do today that weren't possible in the past, and that that allows the system to be more efficient in the way that it delivers a service, is one I entirely agree with.

[54] **David Rees:** Okay. John, on this question. No. Okay, we'll move on then. Can we go to Darren?

[55] **Darren Millar:** Thank you. Minister, when did you take the decision to write off the overspends for the 2013 financial year for at least two health boards, possibly three?

10:30

[56] **Mark Drakeford:** I think that decision was implicit a substantial time ago, because it is part of moving from the old system to the new system. So, we have a new system in Wales put through the Assembly, a new three-year funding arrangement, and the decision to not carry forward debt from the old system into the new system, and I think it was implicit from the very beginning. It's a fresh start and so on. When all the health board accounts for last year are finalised and have been signed off by the auditor general, which we expect by the end of this month, then I will formally set out the position for all health boards in relation to that decision. But until those accounts are formally brought to an end, I'm not able to do that. But, I expect to do that very soon after the end of this month.

[57] **Darren Millar:** You're singing to a very different tune than you were singing to last

year, when you said that you'd been very clear that you will not continue to provide additional funding to organisations that don't have robust plans in place and continue to incur in-year deficits. In fact, you were very explicit in saying, 'Well, if they've overspent, then they have their qualified accounts and it's up to them to put that right and any overspends have to be recovered within the three-year plans'. That's what you said when you came before this committee. And yet, we found out, not through ministerial statements, but through the accounts, which have now been laid, that in at least two cases, you wrote off nigh on £20 million for Cardiff and Vale University Local Health Board, and nigh on £20 million for Hywel Dda Local Health Board. How is that showing financial responsibility and engendering financial responsibility in those organisations? It's just another bail-out, isn't it?

[58] **Mark Drakeford:** Chair, the Member is mixing up two things: he's mixing up two financial years and he's mixing up two different financial regimes. I'll repeat what I said again: organisations that are within the new three-year regime—

[59] **Darren Millar:** Why didn't you say this last year?

[60] **David Rees:** Let the Minister answer.

[61] **Mark Drakeford:** I don't want him to repeat what he said, if that's what he's going to do—

[62] **David Rees:** Darren, let the Minister answer the question.

[63] **Darren Millar:** Why didn't you—?

[64] **David Rees:** Darren, let the Minister answer the question.

[65] **Darren Millar:** Okay. I'm just wondering why he didn't say this last year.

[66] **Mark Drakeford:** I'll answer the question in my way, Chair, and the answer to the question is this: as I said last year, in the new three-year regime, organisations have to balance their books over the three-year horizon. Because we have a new regime, I have decided not to expect boards to carry into the three-year regime debts that they had incurred under the previous regime. We're drawing a line under that and we're moving into the new regime. In the new regime—I'll repeat what I said before—organisations have to live within their means over that three-year horizon. If they fail to do so, no doubt the auditor general will take the necessary action.

[67] **David Rees:** I'm going to let Darren come back, but I want to clarify one point first.

[68] **Darren Millar:** I'm not finished yet.

[69] **David Rees:** I'll come back to you, Darren. The three-year regime you mention I understand, but there are some boards that are still operating on a one-year regime at this point in time. What is their position currently in that case in relation to that particular matter?

[70] **Mark Drakeford:** I think the auditor general has been very clear in his interpretation of the requirements of the new Act and all organisations, whether they have three-year plans or not, have to balance their books over a three-year period or the auditor general will deal with their accounts on a qualified basis.

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

[72] **Darren Millar:** It's a very different message, frankly, Minister, than the one that you

were giving last year. You could have told us last year that you were planning to write these off in the following financial year, couldn't you? But you decided not to do that. If I can just turn to the tables that you provided the committee with in terms of total allocations in February and March, which are in your paper. There's a £59 million sum that has been broken down, not by health board, but broken down according to the reasons for the cash allocations. I can't see anything in there regarding the PAYE and pension contribution that was made to Betsi Cadwaladr University Local Health Board earlier this year. Is there any reason that that's missing from the list, or in which line is it included?

[73] **Mark Drakeford:** I'll ask Martin to be clear about it, but my understanding is that the matter to which Darren referred was a cash management issue, whereas these are actual allocations of resource. They're not the same thing at all.

[74] **David Rees:** Martin, are you able to provide any detail?

[75] **Mr Sollis:** That's exactly right. At the year end, we look at the cash management arrangements of all organisations. In order for them to maintain payroll payments and other payments, then we will always look at those cash issues. Cash follows resource allocations, when that cash is needed—. In this circumstance, with Betsi being in deficit, we were constantly working through at the year end with them in terms of making sure the cash management, pay and other key creditors could be met. That's a commitment that we've made. The resource was held centrally. Their accounts will show the deficit; they'll be held accountable for that. They will repay any assistance as part of the three-year planning regime. The cash issue is one of ensuring that people on payroll, staff, and other issues are paid through that period.

[76] **Darren Millar:** Okay. So, that's cash that has got to be repaid.

[77] **Mark Drakeford:** It is.

[78] **Darren Millar:** And, you're not going to change your message next year on this one, are you, Minister?

[79] **Mark Drakeford:** I didn't change my message last year. As the Member now well knows, as I've explained it to him twice.

[80] **Darren Millar:** I think that everybody's heard what you said, and they heard what you said last year. Can I just ask, then: can you confirm—?

[81] **David Rees:** One fast question because Elin wants to come in as well on this.

[82] **Darren Millar:** It's an important question—have any of those sorts of loans been extended to other health boards across Wales, then, in the last financial year?

[83] **Mr Sollis:** In cash-management terms, the only organisations that were looking at any consideration of deferring HMRC payments and pension payments were Cardiff and Betsi, and in both cases, we have given cash support in order to help them meet those requirements—it's not all of the requirements—but to meet those requirements. My understanding—confirmed through the accounts process—is that, recently, those obligations have been met. Those are statutory obligations, they're required to pay them the following month, and those obligations have been met.

[84] **Darren Millar:** And in terms of the performance of those organisations that have three-year plans, are they on target to achieve their three-year plans or not?

[85] **Mark Drakeford:** They have to achieve it over the three-year horizon, Chair, so—

[86] **Darren Millar:** But they have a year 1, 2 and 3, don't they?

[87] **Mark Drakeford:** They have year 1, 2 and 3, and they will all be on different trajectories, and they will all have different patterns in which money is spent in one year and returned in another. It's a matter that we watch very carefully indeed, and it's not always easy for health boards to live within the means that we are able to provide for them. But, over the three-year horizon, that's what the law requires them to do.

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

[89] **Darren Millar:** Just one final question, Chair.

[90] **David Rees:** No, Elin's going to come in now.

[91] **Elin Jones:** Well, I do want to return to the initial point that Darren Millar raised, and your answer, Minister, because you've explained your understanding of the situation, but I'd just like to be clear when you took the decision to bail out, or whatever term you choose to use, the health boards on their 2013-14 end-of-year deficit and move on to the new three-year financial planning, because, quite clearly, in the auditor general's report on the NHS in Wales, in October 2014, his understanding was that the

[92] 'the department will not only require repayment of any 2013-14 brokerage funding in 2014-15, but also repayment of any "deficit" by those NHS bodies not meeting their financial targets.'

[93] So, the department had led the auditor general to believe that those end-of-year deficits would not be paid out by Welsh Government, although you seem to suggest that your ministerial understanding or expectation of the situation was different.

[94] **Mark Drakeford:** Chair, you are always having to balance, in the way that you do things, the need to try and maintain as much financial discipline and rigour in the system as you can, while trying at the same time to make reasonable decisions that do not hamstring health boards in providing services to their local populations. I think it was completely clear during the debates we had leading up to the new regime that it was to be a new way of doing things in Wales, and the things that were done under the previous one-year regime would not necessarily continue into the new three-year one. So, the general intention, I think, was clear from the beginning.

[95] Specifically communicating to local health boards that they would not be required to pay debts that they had incurred under the old regime did not take place until towards the end of the last financial year, and that's because I have to make sure that health boards are firmly focused on their obligations to live within their means. And I don't want to send them messages that there are easy ways out for them when they fail to do that. So, it's balancing the two things all the time. The general intention, I think, was clear from early on. The specific decision, communicated to health boards, that we would not be looking for them to repay debts incurred under the old regime wasn't communicated to them until towards the end of the last financial year, in order, as I say, to keep a strong message with all our health boards about the importance of meeting their financial obligations.

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

[97] **Elin Jones:** I understand the dynamic of the decisions that you take as a Minister, when you take those. But I'm still unclear why the department chose to give such clear

understanding to the auditor general that repayment of all deficit from NHS bodies would be required in October, or in advance of October 2014, when, as you've described it, your general understanding was that you were moving into a new three-year regime. It sounds as if the information given to the auditor general was different to the general view that you were taking as a Minister at the time.

[98] **Mark Drakeford:** No. I think the difference is simply this: the general intention was there and was clear; the specific intention to allow health boards not to have to pay back debt that they had incurred under the old regime was not communicated to them until after the date of that report of the auditor general. Therefore, he would have been technically correct in what he said.

[99] **Elin Jones:** Just to round this off, perhaps we could have clarification from the Minister on when exactly the health boards were communicated the information—

[100] **Mark Drakeford:** Yes, happy to do that.

[101] **Elin Jones:** —from the Minister on his decision not to recover the money allocated.

[102] **David Rees:** Last question, Darren, because we need to move on.

[103] **Darren Millar:** I just wanted to ask: obviously, four out of seven health boards required—or three of them at least, required—additional resources, or had overspends in the financial year, and spent outside their envelopes. To what extent are you using the new escalation regime in monitoring those health boards? Obviously we know about the situation in Betsi Cadwaladr, but what about Cardiff and Vale, and what about Hywel Dda? Are they subject to any kind of enhanced monitoring regimes or intervention?

[104] **Mark Drakeford:** Yes, both of them are. Chair, I think I rehearsed Cardiff's position in front of the committee when I was last here, because it had just moved up into the next level of the escalation regime a couple of weeks before I appeared here last for general scrutiny. It was very much around the emerging financial situation there that that decision was taken.

[105] **Dr Goodall:** And, yes, it has been a factor in terms of Betsi Cadwaladr; that was very clear, as part of the targeted intervention process that was put in place—and equally for the special measures aspect, as well. Also for Hywel Dda in respect of enhanced monitoring, given the materiality of the financial position. There are other organisations that are in enhanced monitoring for different purposes. Abertawe Bro Morgannwg, for example; that was not driven by financial delivery. In fact, they met their financial targets through the year and to the year end at this stage, although subject to the auditing process, of course. We will continue to review those mechanisms under the escalation frameworks. We have two points in the year, as I know Members are aware, where we review the escalation framework. The next meeting will be scheduled to take place over the next two or three weeks or so, and we will take a look at the year-end position and make further judgments alongside HIW and the Wales Audit Office.

[106] **Darren Millar:** So, just to be clear, you've got Hywel Dda and Cardiff and the Vale both on enhanced monitoring levels, rather than targeted intervention.

[107] **Dr Goodall:** Yes.

[108] **Darren Millar:** And that enhanced monitoring is just you keeping a closer eye on how they're managing their resources.

[109] **Dr Goodall:** It increases the level of contact with them. We have expectations about improvement; it meant that, during the last quarter of the financial year, we were looking at the progress being made. We could clearly see with both organisations that they were able to demonstrate an improving position. But, of course, we use the three-year plan process and the sign-off of the integrated medium-term plans to really look at whether there is a need to change those escalation levels going into the new financial year. That is part of the process that we've put in place there.

[110] **Darren Millar:** So, what was the scale of the deficit they were expecting before your enhanced monitoring arrangements began?

[111] **Dr Goodall:** We would have expected, with Cardiff's situation—they were under an approved plan regime—we would have expected that they would have been managing within their resources through the course of the year, and it was quite clear as the months were elapsing that there was a deterioration in their financial position. That was part of the clarity about the enhanced monitoring regime that needed to be in place. We continue to manoeuvre those forward as well, as a team, in support of Ministers. We actually had the end-of-year review for Cardiff; what was very clear from that review perspective is a sense of an understanding of the financial position, that they were able to demonstrate improvement during the last period of the financial year. They take some of that through into some confidence about where Cardiff can be during the course of this year within its IMTP as well.

[112] **Darren Millar:** So that improvement was as a result of the enhanced monitoring—

[113] **David Rees:** We need to move on. John and then Kirsty. Then, we need to look at—. Because we are still on the financial considerations.

10:45

[114] **John Griffiths:** Can I just ask about capital, Minister? We touched earlier on the equation of pulling provision out of the acute sector into the community setting, and I know that, in my area, there's some frustration that some of the planned health centres haven't yet gone ahead, and people often talk about the need to get the community infrastructure in place before those services are pulled out of the acute sector. So, I just wonder, in terms of the capital prioritisation exercise that's gone on within the department, and I know that the committee's had some exchange with you on this, whether, looking forward, we will see prioritisation that will allow that transition to take place in a properly planned way that will not leave any gaps, in terms of making sure that the community provision is there before it's pulled out of the acute sector.

[115] **Mark Drakeford:** The capital challenge that faces public services in Wales is at least as difficult as the revenue challenge, if not more. We have a 30 per cent cut in the level of public capital available to public services in Wales, and that has a very direct impact upon the health service and our ability to do all the things that we would like to do. We had significant additional assistance from the finance Minister in the last financial year, always looking to see whether there are any opportunities for capital to be provided to the health service, and always keen to be sympathetic to that. But our capital programme in this year is many, many, many millions of pounds less than it would have been just three years ago, so the capital prioritisation exercise is very real and very sharp. By the time I have allocated the discretionary capital that we must give to our local health boards to attend to much smaller but necessary things that they must do, and complete the major schemes that are already in the pipeline, as the ones at Morriston, for example, 85 per cent of the capital available to me in this financial year is already committed, leaving a very small sum of money indeed, and therefore I have to prioritise those schemes that are genuinely re-engineering the service provided in that area, that does some of the things that we've talked about already today about

moving services into the community, and that prioritises primary care and community services. So, in the programme for this year, I'm very pleased that Cylch Caron is there, because it does all of those things. I'm holding money there for Flint and for Blaenau Ffestiniog, because those are really important changes in north Wales that we have to demonstrate to their local population about things that they were promised will happen, and there are some other schemes of that sort that I still hope to be able to progress in this year. But the test, the bar, for local health boards in putting forward schemes is getting higher and higher, and unless they are able to demonstrate to me that capital investment doesn't simply sustain a service, but changes the service, and that it drives out revenue savings as a result of capital investment, they're very unlikely to find themselves in the part of the programme that actually gets funding.

[116] **David Rees:** Kirsty?

[117] **Kirsty Williams:** As service re-organisation happens, we're going to have more and more people travelling across local health board borders to receive their treatment, and, therefore, I'm returning to my concern about how money flows throughout the Welsh NHS, because it's pretty opaque, and sometimes our commissioning arrangements are not as strong and as clear and as transparent as they could be. You were going to do some work on this, and I wonder if you could provide an update on how that is happening. And, whilst it's inevitable that you are stuck with the day-to-day challenge of how you find the money to find the health service, we have to look to the future as well. In England, the chief executive there has been very candid about the kind of money he expects politicians to find to sustain the English NHS—£8 billion. You've commissioned work to look at what will need to be done here. What is your current analysis of the additional resources that you will need to find to sustain NHS provision in 2020?

[118] **Mark Drakeford:** Thank you, Chair. Martin, I think, will probably give you the detail on the work that we are doing in terms of cross-border flows of patients, but it's a very important point. Up until now, we've had a system that sort of deals with cross-border flows on a knock-for-knock basis—that it all sort of comes out in the wash in the end, because cross-border flows are at the margin of health boards' financial considerations. They're not going to be like that in the future. The three healthcare alliances in south Wales will mean that patients will move much more often across boundaries and we need a system, but not a system, I believe, that ends up with lots and lots of money being spent on accountancy, with people chasing bits of paper and bills. It's got to be sensible system, but a transparent system where people can see where money is going.

[119] In relation to the broader question of how we plan for the resource we need in the future, we are still using the Nuffield analysis that we published last year as our main guide. Nuffield said that the Welsh Government needed to provide £221 million extra in this financial year in order to allow the service to stay afloat. We provided well beyond that, in fact. Nuffield then makes three predictions for the future: flat cash, flat real and a 2.2 per cent real-terms increase. If we get the third, which is the one I think we should be getting—it's the one that has sustained the health service over its 65 years—. Mrs Thatcher provided a 4.6 per cent real terms increase year on year to the health service, so we're looking for less than half of what we were provided during those years. And, if we get that, Nuffield says, and if we continue with the efficiency measures that Nuffield identified in terms of reducing length of hospital stay and managing people with chronic conditions in the community, then the gap into the first part of the next decade is another £200 million. And that, I think, from a Welsh Government perspective, is not easy but ought to be within the realms of the possible.

[120] If we are denied that, if the money that flows to Wales via the Barnett formula does not provide 2.2 per cent real-terms growth year on year, then the figures become far bleaker and very different sorts of decisions would need to be made by anybody in charge of the

health service to live within those very much reduced means. Now, we don't know yet, because we await to see what the budget on 8 July tells us, but we are already, this week, managing with £50 million less than the Welsh Government had 10 days ago to provide for public services in Wales in this financial year. So, we approach 8 July with some considerable pessimism. But let's wait to see.

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

[122] **Mark Drakeford:** Martin could say something about the work is going on on the cross-border—

[123] **Ms Sollis:** There's work still going on with directors of finance and chief executives around the internal arrangements within Wales and around what I would call cross-LHB boundaries. We're about to get a report on that quite shortly, and I can update separately in relation to that issue. In terms of cross-border issues, we're currently talking to the Department of Health around some of the changes that are going through in legislation—or that are proposed in legislation—and some of the issues around that issue.

[124] **Kirsty Williams:** It would be helpful to have an update because it seems the department has been working on this for a long time.

[125] **David Rees:** Maybe a reply—

[126] **Mark Drakeford:** Of course.

[127] **David Rees:** Thank you, Minister. I'm very conscious of the time, and we've spent a lot more time on the financial than we have on the general. I want two specific questions from Elin and Kirsty on general that I want to let them raise. Just one question from myself. You talk about the £8 million on the Welsh Ambulance Service NHS Trust funding, and the Emergency Ambulance Services Committee has actually raised concerns over the progress and the improvements that money should be making. In particular, we are seeing progress and improvements in our response times, but, clearly, we are working towards the winter. As we always point out, winter comes every year. What are your concerns as to the improvements and preparations WAST are doing in using that £8 million you allocated particularly to that purpose?

[128] **Mark Drakeford:** I'll ask Vaughan to deal with that.

[129] **Vaughan Gething:** Yes, thank you. The initial £8 million was non-recurrent. You've seen it come out in the winter pressures. That's now been made recurrent by EASC. It's interesting the way they're using it to try and drive service improvements. So, they're looking at a number of pilots across Wales and how they can inform the whole system for improving the quality of the service. So, it's not simply about the performance measures on response times. It's also about the quality of service and the quality of outcomes. So, for example, the pilot in Cwm Taf is not simply a return to footprint; it's actually about how you manage the relationships between primary care clinicians and their call on the service. So, the improvement that you're seeing there is about both those things; it isn't just one part of it.

[130] I'm pretty encouraged by the robustness and the level of scrutiny that the commissioners provided for, not just how the money is used but to really understand the detail of what needs to change to see improvement made and sustained. For example, the work being done on how and when staff are rostered, so that you have staff meeting demand and expect demand profiles, has made a significant difference to the improvement on response times as well. They've got a pretty robust system of reviewing each of those pilots and reviewing the level of performance and improvement that they expect to see. They've got

a properly set out performance and quality delivery framework. I know, when you return to look again at ambulances over the autumn, I think you're going to see some of the emerging evidence on a more robust basis for those pilots and what it means for the whole service.

[131] So, I'm positive that money is being used effectively, in a way that the emergency ambulance services committee understands it's being used because of the way the commissioning service is now working much more effectively than we would have said it was 12 months ago. That's a very positive thing, not just for health boards and WAS, but also for the patient, because I think we'll be able to demonstrate a much greater level of useful information about what will improve the patient experience and patient outcomes in the way that WAS does its business with health boards as well.

[132] **David Rees:** Thank you for that answer. I want to move on to general questions. There are just two topics as we haven't got the time. I want to let Elin and Kirsty come in, please.

[133] **Elin Jones:** Mine's on medical education and medical workforce planning. You've expressed a concern previously, Minister, on the investment that goes into medical education in Wales and medical training, and then the lack of return to the NHS from that. It was equally there in the report, which was commissioned recently, by—was it Mel Evans?

[134] **Mark Drakeford:** Mel Evans.

[135] **Elin Jones:** Yes. So, I wanted to know what actions you are intending to take or are taking to ensure that the money that we are spending in Wales on medical education—that more of that is retained for the benefit of the Welsh NHS right throughout Wales.

[136] **Mark Drakeford:** Thank you, Chair. So, Elin is right; we published the Mel Evans review. We then offered a period of six weeks to those people who had contributed to the review or had an interest in it to comment on it. It turned out to be a richer exercise than maybe we had anticipated. There were 70 replies, which was a large number. So, there was a volume of replies, but there was a depth of detail in some of those replies as well. I met earlier this week with the senior civil servants who've been leading on that, and my intention is to reconvene the panel relatively briefly. I think—

[137] **Elin Jones:** The review panel?

[138] **Mark Drakeford:** The review panel. Given some of the views that are expressed about the panel's conclusions I think it is fair for the panel to have an opportunity to reflect on what has been said, to offer any amendments to their conclusions where they feel new evidence has emerged that would lead them to do that, or to defend their conclusions, where they feel that they came to the right conclusion even though others don't agree. I expect to get that advice back from them during the summer and then to make a statement on the way that we will take forward the final position by the time we're back here in September.

[139] **Elin Jones:** Okay. That's fine.

[140] **David Rees:** Kirsty.

[141] **Kirsty Williams:** I want to talk about the balance between elective and emergency work. In the document that the Government published yesterday, it states that the number of emergency admissions actually has remained pretty stable. If you look at the graph, it's a pretty straight line since 2005-6; yet, in the same document, it also then goes on to say that the Welsh NHS has struggled to meet its referral-to-treatment targets. If you look at that graph, everybody was seen within 26 weeks in December 2010, when you would have

thought that they would have been at the height of the winter pressures. Every December since, the ability to do that has decreased, decreased, decreased. I'm just wondering how we maintain an elective service for 12 months of the year rather than what it seems to be at the moment: we run an emergency service all of the year round and an elective service for part of the year. I'm sure your ambition will be to be able to do both for 12 months of the year, but it seems, from your own statistics and the big jumps we've seen in surgery waiting lists over the last 12 months, that the NHS is struggling to do that, and I wonder why that is.

[142] **Mark Drakeford:** I'll just make one observation and then ask Andrew or Vaughan if they want to—. What I am always told when I ask exactly that question is that the numbers are one thing, the nature is another, and that the people who are coming in through the door as emergencies are more complex, more frail, take longer and stay in the system for longer than previously. So, it's not just the numbers, but it's the nature of the demand as well, which is having an impact on the ability of the system to find capacity to do other things.

11:00

[143] **Vaughan Gething:** I was going to make the same point: so it isn't just the numbers, but the type of patient coming through the door—

[144] **Kirsty Williams:** The First Minister constantly tells me that demand is the issue and that demand is going up.

[145] **Vaughan Gething:** But the nature of the demand is changing, and you'll know this yourself—every year there's evidence about—. And you heard it in the earlier answers about the average age of people coming through the door throughout winter and the impact of winter on older people in particular, and having a much older and frailer population here. Everyone in this room knows that we broadly have an older, more frail and, broadly, poorer population than in other parts of the UK as well, so the demand here is different.

[146] In terms of the elective work, our ambition is for the work to continue over 12 months, but we do know that in the winter, the capacity will mean that there will be less elective work. It's about how the whole system manages, over that 12 months, to meet its targets. If you look at profiles that say you are going to increase elective activity throughout the winter months, I don't think most people would expect that to be the case, because, as Altaf was saying earlier on, we do know that winter turns up every year and so part of our challenge is how we manage winter plans to take account of the demand that we can expect, which we won't be able to accurately predict, and how that leads into the impact on elective work with the performance measures and expectations that we have. So, it's not simple, but it's a challenge that health boards are aware of. From where we are now and the improvements to the end of the last financial year on referral to treatment, and what we need to see over this winter and through the autumn before we get to next winter, that's part of the challenge that people understand upfront and central.

[147] **David Rees:** Andrew? I'm conscious of time, Minister.

[148] **Dr Goodall:** I would hope that given the approaches that we've taken in Wales over these recent years, not least the integrated structures, we have managed to find a way in, stabilising our emergency admission rates to different degrees. The Nuffield Trust report actually clarified that. I think the nature of the patients, who were left coming into our system, therefore, are more dependent and, as has been described, have a high acuity and can end up with extended length of stays. We've seen our minor attendances in A&E departments reduce, but, proportionately, actually grow on the major side. So, there's been 18 per cent growth, for example, on majors within the A&E system.

[149] I think there will always be a demand-led issue; there'll be a high level of activity happening in the winter months and I think we do need to plan for that. But I think your point is right in that we also need a more consistent level of elective activity. Even during this last winter period, we were still bringing in between 30,000 and 40,000 elective admissions across a whole variety of different settings within the Welsh system, which compensates, actually, for some of the emergency pressures as well. So, we still have a level of normality, but we still have to deal with the peaks that happen within those pressures as well.

[150] **David Rees:** Kirsty, I'll give you one last chance to come back.

[151] **Vaughan Gething:** I've got to be somewhere in two minutes, Chair.

[152] **Kirsty Williams:** That's fine; I'll write.

[153] **David Rees:** Thank you, Minister. We had some other questions, but we will write to you with those, if that's okay. Thank you very much for your time. You will obviously receive a copy of the transcript and if there are any factual inaccuracies, please let us know. Once again, thank you very much for the evidence this morning. I thank the officials as well.

11:03

**Cefnogaeth i'r Bil Lefelau Diogel Staff Nyrsio (Cymru): Cynnig i Gau'r Ddeiseb
Support for Safe Nurse Staffing Levels (Wales) Bill: Proposal to Close the
Petition**

[154] **David Rees:** Can we move on to item 5, which is the support for the Safe Nurse Staffing Levels (Wales) Bill that we received from the Petitions Committee? That's in your papers. What we propose to do is to write to the Petitions Committee indicating that Stage 1 has now been completed and has gone through the Assembly's process and, in fact, we should inform the committee that we believe that the petition should now be closed because, as a committee, we no longer have support for it in one sense because it now goes to the National Assembly in Stage 4 as a Bill. We will look at amendments—

[155] **Kirsty Williams:** Sorry, but do you want me to leave?

[156] **David Rees:** No, because this is the petition. As amendments will be coming through, we will discuss those, as—*[Interruption.]* Okay, in that case, we'll just write to it. Thank you very much.

11:04

**Papurau i'w Nodi
Papers to Note**

[157] **David Rees:** Item 6 is on papers to note. We've received the minutes of the meeting held on 21 May and 3 June. Happy? The additional information we received in relation to the Regulation and Inspection of Social Care (Wales) Bill is from the various itemised groups: the Fostering Network, the Commissioner for Older People in Wales, the Minister for Health and Social Services, Children in Wales, the National Society for the Prevention of Cruelty to Children, and the Finance Committee. Are you happy to note those in relation to the Bill? Thank you for that.

11:05

**Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o
Weddill y Cyfarfod ac o'r Cyfarfod ar 25 Mehefin**
**Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from
the Remainder of the Meeting and from the Meeting on 25 June**

Cynnig:

Motion:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac o'r cyfarfod ar 25 Mehefin, yn unol â Rheol Sefydlog 17.42(vi).

that the committee resolves to exclude the public from the remainder of the meeting and from the meeting on 25 June, in accordance with Standing Order 17.42(vi).

*Cynigiwyd y cynnig.
Motion moved.*

[158] **David Rees:** Moving on to the next item, in accordance with Standing Order 17.42(vi), I propose that we now meet in private for the remainder of this meeting and for the totality of the meeting on 25 June. Are Members content? Thank you. We therefore move into private session.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 11:05.
The public part of the meeting ended at 11:05.*