



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

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

**Dydd Mercher, 25 Ionawr 2012  
Wednesday, 25 January 2012**

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

### **Aelodau'r pwyllgor yn bresennol Committee members in attendance**

Mick Antoniw	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour

Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

**Eraill yn bresennol  
Others in attendance**

Lesley Griffiths	Aelod Cynulliad, Llafur, y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol Assembly Member, Labour, the Minister for Health and Social Services
Dr Chris Jones	Cyfarwyddwr Meddygol, NHS Cymru Medical Director, NHS Wales
David Sissling	Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director General for Health and Social Services, Welsh Government

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

Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Gregg Jones	Pennaeth Swyddfa'r UE Head of EU Office
Victoria Paris	Y Gwasanaeth Ymchwil Research Service

*Dechreuodd y cyfarfod am 9.29 a.m.  
The meeting began at 9.29 a.m.*

**Cyflwyniad, Ymddiheuriadau a Dirprwyon  
Introduction, Apologies and Substitutions**

[1] **Mark Drakeford:** Bore da a **Mark Drakeford:** Good morning and  
chroeso. Nid oes gennym unrhyw welcome. We have received no apologies for  
ymddiheuriadau'r bore yma. Fel arfer, bydd y this morning. As usual, the microphones will  
meicroffonau i gyd yn gweithio yn all operate automatically.  
awtomatig.

9.30 a.m.

**Craffu ar Waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol**  
**Scrutiny of the Minister for Health and Social Services**

[2] **Mark Drakeford:** Croesawaf y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, Lesley Griffiths. Rwyf hefyd yn croesawu Dr Chris Jones, cyfarwyddwr meddygol GIG Cymru, sydd yma am yr ail dro, a David Sissling, cyfarwyddwr cyffredinol iechyd a gwasanaethau cymdeithasol Llywodraeth Cymru. Byddwn yn dilyn y drefn arferol. Byddaf yn gofyn i Lesley os hoffai wneud datganiad byr ac, ar y diwedd, os bydd amser yn caniatáu, down yn ôl at y Gweinidog am unrhyw sylwadau pellach.

**Mark Drakeford:** I welcome the Minister for Health and Social Services, Lesley Griffiths. I also welcome Dr Chris Jones, the medical director of NHS Wales, who is with us for the second time, and David Sissling, the director general for health and social services for the Welsh Government. We will follow the usual pattern. I will ask Lesley if she would like to make a short statement and, at the end, if time allows, I will ask whether she would like to make any further comments.

[3] So, Lesley, would you like to make any opening remarks before we move on to the questions?

[4] **The Minister for Health and Social Services (Lesley Griffiths):** Thank you very much, Chair. I am very grateful for the opportunity to come here today to highlight some of our achievements and outline the key work that we are undertaking to deliver the Welsh Government's commitments to the NHS in Wales. NHS Wales has made significant progress with regard to improving the performance of its services to patients. For example, the latest ambulance performance figures show that, in November, 70% of category A responses were answered within eight minutes, against a 65% target. This is the tenth successive month in which this has been achieved. Performance against the 95% four-hour maximum wait in accident and emergency departments has also shown a steady improvement in recent months. The 31-day cancer target has been achieved in 25 of the last 26 months, and performance against the 62-day target has also improved in recent months.

[5] Tackling healthcare-acquired infections is also a priority. As we know, it saves lives, prevents unnecessary suffering and reduces costs to the NHS. Last month, I launched a new framework of actions for healthcare organisations.

[6] We are also maintaining our investment in health and social services in cash terms. It has 43% of the budget, so the largest single proportion of our overall budget is being invested in health and social services. Nearly £700 million of capital investment is planned for the next three years, which includes a large variety of schemes to bring existing facilities up to modern-day service and infrastructure standards. Our investment is clearly making a real difference to the construction industry in Wales, with building work continuing on the £30 million Merthyr health park. Members will also be aware of the completion of Ysbyty Ystrad Fawr in Caerphilly.

[7] We are also taking forward a very challenging and ambitious legislative programme. I have set out the progress of the programme in the evidence paper. However, it is important to recognise that there is significant non-Bill legislative work going on. For example, the Mental Health (Wales) Measure 2010 continues to progress very well, with Part 4 being implemented this month. Good progress continues to be made with our programme for government commitments, with my officials looking at arrangements to ensure that we monitor our progress with key indicators. I think that is very important and I will be issuing a full progress report to the Assembly in May.

[8] Finally, our service change programme is now under way. The national clinical forum has been set up to look independently at local health boards' plans for the future delivery of health services. In line with that, I have made it clear that any health board proposals for service changes must be based on clinical consensus and have full engagement with local communities. I look forward to answering your questions.

[9] **Mark Drakeford:** Thank you very much indeed for that, Minister, and thank you for your paper, which we have had a chance to read in advance of the meeting. I will take questions from anyone who wants to ask them. I will start with Darren.

[10] **Darren Millar:** Thank you, Minister, for your paper. I thought that it was very complacent on the ambulance response times. It is true that the service met the target, but it is still worse than other parts of the United Kingdom. I thought that it was very complacent on the accident and emergency four-hour target, which is still being missed by every local health board. Of course, we also have stubbornly high waiting lists in Wales, particularly for orthopaedics. There are no signs of that improving at all, or certainly not rapidly enough to hit your target by the end of the year. Having said that, there was some useful information in your paper, particularly about local health board reorganisation and the service change plans. Could you give us a little more information about the way in which the national clinical forum might work? Do you envisage any plans that may emerge going to the forum? It could then make a recommendation to you that you do not subscribe to. Given that you have said that the buck stops with you, does it really stop with you, or will you just be rubber-stamping recommendations that the forum might make?

[11] **Lesley Griffiths:** In relation to targets, some of them are not where you would want them to be, but we should all recognise and congratulate NHS staff on the fact that many of the targets are being reached. People are accessing services within the target times in a huge, wide area, so I am certainly not complacent, and I reject that.

[12] In relation to the national clinical forum and the service reconfiguration plans, I set up that forum as an independent body to oversee the plans, and to make sure that there was a clinical basis for them. I have been quite surprised at the criticism that the NCF has had from certain quarters in the Assembly. In fact, both Northern Ireland and Scotland are looking at the model, and Northern Ireland is certainly going to implement one. I am sure that Plaid Cymru Members will be interested that Scotland is looking at it closely, and is thinking of having one too. The forum has met three times already and is overseeing the plans. It is there to advise, not to say, 'You must do'. It is there to give the health boards advice, and to oversee. For example, there are two members of the national clinical forum who are there specifically to look at rural health issues. When I say that the buck stops with me, of course it does: if there are appeals, then they will come to me. That is why I cannot get involved at this stage. Some Members seem to think that I should be there at the beginning, but I should not. I am there at the end. I set the direction, and it is up to the local health boards to plan services for their local population and ensure that they are of a high quality and are safe and effective.

[13] **Darren Millar:** May I ask a supplementary? I found that turn of phrase interesting—'if there are appeals'. It seems to me that you are effectively trying to wash your hands of this. In the same way that the planning system works, with the inspectorate effectively making decisions, you want to stand back and shirk your responsibility as a Minister. Is it not fair for the public and for politicians, frankly, to be sceptical about the role that the national clinical forum might play when you use phrases like 'if there are appeals'? That essentially sounds to me as though you do not want to be involved in the decision-making process, and you can say, 'Nothing to do with me—it was their decision', unless there is huge public outrage. Frankly, there is likely to be outrage in some areas, because people are often resistant to change.

[14] **Lesley Griffiths:** I am disappointed that you think that. What I want is for local health boards—and I have said this time and again—to engage like they have never engaged before. For example, Hywel Dda Local Health Board has put out a DVD, and we are seeing new ways of engagement. Engagement is not just for this process; it should be a continual activity for local health boards at all times. The national clinical forum is there as an independent body to have a look at the plans and to advise. It is there in an advisory role to the local health boards. I am not shirking my responsibility. I have said before that I cannot micromanage the NHS, and, as the process goes forward, at the end, if there are appeals to be dealt with—and I hope that there are not, because I hope that the engagement is so good that they take the public with them—then that is my role.

[15] **Darren Millar:** May I ask one final question? In terms of an appeals process, is that process clear and how is it being communicated to members of the public? I welcome the fact that you have said in the past that local health boards need to work harder to engage with members of the public and to consult with them when service change is being proposed. You will know that there has been a lot of concern about some of the recent decisions about minor injuries units, for example, and the lack of involvement of the public in that process. How will you ensure that the public is aware of the process, in the same way as it might be aware of the planning process, so that it knows how it can intervene and influence?

[16] **Lesley Griffiths:** It is set up in the statutory responsibilities of the LHBs. I will pass over to David.

[17] **Mr Sissling:** It is actually very clearly established, as it needs to be clearly understood within the system. The community health council has a critical role in this, being responsible for ensuring that there is good process in terms of engagement, and, if necessary, the formal consultation. At the conclusion of that, it has to form a view about the degree to which it is satisfied with process and outcomes. If it is dissatisfied, then there is a very clear process in terms of referring specific matters back to the health board in question. If that fails to be fruitful, at that point, the formal appeal will be made to the Minister for consideration. The process, circumstances and roles of the different organisations as events unfold have been clearly set out.

[18] **Mark Drakeford:** My intention is that every Member gets a chance to ask some questions this morning. So, we are going to have to move along a little bit. We will turn to Vaughan next and then to Lindsay.

[19] **Vaughan Gething:** I have one question on the national clinical forum and what you said in that regard. I was interested in what you said about creating clinical consensus, because one of the difficulties, of course, is that there is almost always a clinician somewhere who disagrees with the direction of travel. How do you expect LHBs to reach a clinical consensus and what role might the NCF have in trying to direct what that consensus might be?

[20] **Lesley Griffiths:** As I mentioned, the NCF is an independent body. It is there to advise. The LHBs do not have to take its advice. You are absolutely right; it is so much easier when you have clinical consensus. That is why clinicians have to be on board at the beginning. They are probably the first port of call for the LHBs to engage with, and then they need to engage with the public. So, the LHBs recognise that they have to take the clinicians with them, and I think that is one area where they have really upped their engagement. What I have said now is that they need to up their engagement with the public to ensure that they take the public with them too. As Darren said, people are resistant to change, and they get attached to their local hospitals. So, it has to be a two-way process between the public and the LHBs.

[21] **Vaughan Gething:** Turning to a slightly different subject, looking at the money and each local health board's situation, we know that they have all had to make significant savings. Are you satisfied that they are on target to do that? We have all had representations from local representatives and individuals about what is going on within the local health board. I am interested to know whether you are still confident that each LHB will come in on budget, because you have been clear before that there is no money.

[22] **Lesley Griffiths:** There is no more money. You are right; I have been clear and I have said that time and again. I recognise that what I am asking the LHBs to do is difficult. However, I am confident that they will come in on target. There is no more money. They had the money upfront to enable them to organise themselves, so that they would come in on target. There are some concerns that we are not quite there with a couple of LHBs, and officials are monitoring the situation extremely closely. I think that the overall financial risk now, based on the most recent forecasts I have had from NHS organisations, stands at around £16 million, which we have to recognise is 0.03% of the entire budget. Obviously, all NHS organisations are taking further action to manage the risk and my officials are working very closely with them to provide support and advice.

[23] **Mark Drakeford:** There is another brief question on this point.

[24] **Mick Antoniw:** The recent select committee report in England talks about achieving targets there, of course, but what is happening, effectively, is what they call salami-slicing. To what extent are you confident that that is not happening here, so that we are achieving savings through reorganisation and improvement rather than some sort of panicked chopping of services right at the end?

[25] **Lesley Griffiths:** I am very confident. I have told LHBs that this cannot be done at the cost of services. We are still seeing delivery of services. We are seeing better performance. So, they are adamant that that is not happening in Wales.

[26] **Vaughan Gething:** You say in your paper—and you have just said this again—that you think there are still £16 million of savings to be achieved. You say it is a small portion of the budget, but what happens to LHBs if they do not balance their budget? What do you then do, given that you have already said that there is no more money? What is the role of the Government in terms of that budget not being balanced, and is it your responsibility or that of the LHB if they do not achieve targets?

[27] **Lesley Griffiths:** In making any judgment about financial performance, I have to take full account of the scale of the challenge that LHBs have faced. I will consider the extent to which they have been improving against previous years. Any action I take must be proportionate and appropriate to the circumstances. I will hold senior management to account for the financial management of their organisations. They have a statutory responsibility. The NHS has to learn to live within its budget. I think, over the years, it has been bailed out and it has become the norm. That cannot happen anymore, because there is no more money, particularly in light of the additional funding I made available early in the financial year.

9.45 a.m.

[28] At the end of the day, I will hold them to account. If it comes to light that a board or individual directors have fundamentally failed to discharge their financial management responsibilities effectively, I will not have any option but to consider changing the leadership arrangements in that organisation.

[29] **Mark Drakeford:** Thank you very much. We will now go to Lindsay and then to Rebecca.

[30] **Lindsay Whittle:** Minister, my question follows on nicely from that. I have been one of those who has praised the new Ysbyty Ystrad Fawr in the region that I represent. However, I have received a substantial number of complaints and I am aware that many local councillors have received a number of complaints. I do not know yet whether this is because people just do not like change, as you have clearly said. I have a meeting next Monday with the chair and chief executive of Aneurin Bevan health board, so I may come back to you on that. However, I think that we need to fire a shot across the bow—I hate the phrase ‘warning shot’; it is not a warning shot to you personally, just a shot across the bow. I, too, am concerned about overspend on budgets. You have made your position quite clear, and today you have reiterated that you may very well change the leadership of health boards. Minister, with respect, I think that people would expect you to do that. If you were to fail to do that, I think that people would expect you to consider your own career. Have you thought of that, please?

[31] **Lesley Griffiths:** I expect them to come in on budget. That is as far as I have got. I have just set out what will happen if they do not.

[32] **Lindsay Whittle:** That is tough talking from the top, which is what I think we need. However, you are quite adamant that your officials are going to come in on budget.

[33] **Lesley Griffiths:** I think that they will come in on budget, because they had been told very clearly that they have to learn to live within their budget. There is no more money. I expect them to come in on budget. I have explained that there are still concerns. Officials are working very closely with the local health boards providing support and advice, and I expect them to come in on budget. With regard to Ysbyty Ystrad Fawr, do come to me if you are not happy after you have met the chair and chief executive. Personally, I have not received any complaints, but if you want to include me in that, please do.

[34] **Lindsay Whittle:** There are too many complaints and it is worrying me. However, I am not the type of politician to run to the media. I want to try to resolve those complaints first with the appropriate health board. Thank you for your offer. I will certainly take you up on that.

[35] **Mark Drakeford:** Thank you for that. The Minister has been alerted to the fact that there may be issues you will want to take up with her. Minister, you have made your position on the budget very clear now for the committee. Therefore, unless there are questions that are going to take that further, I think that we can regard that as an issue that we have rehearsed. Elin, do you have a question on that specific issue?

[36] **Elin Jones:** Yes, thank you, Chair. I understand, of course, the challenges the budget provides for you, as Minister, and for the local health boards. The savings expected of the local health boards are £456 million in this year. Achieving that level of saving is not going to be, and is not proving to be, easy, I am sure. However, to go back to the reference to salami-slicing, it feels as though there is an element of salami-slicing happening around local health boards in Wales towards the end of the financial year, with news of wards closing temporarily, minor injuries units closing temporarily—even whole hospitals closing temporarily. Can you explain to me your take on why those decisions and announcements are being made at this point by various local health boards?

[37] If I may, I would like to go on to the issue of capital budgets as well. When we discussed the budget in a scrutiny session in the autumn, you said quite clearly that there would be no new commitments for any capital plans until the local health boards’ service plans had been fully decided. Now, there has been a delay in the full implementation of those service plans and you are not expecting them to be completed until September this year at the

earliest. Do you therefore not expect any new capital commitments throughout the NHS until at least September this year?

[38] Finally, not on the budget, but on building engagement with communities to reach the aspirations that you have set for change within the NHS, you have heard me, and other Assembly Members, say before that there is almost a culture of non-engagement in some health boards. You referred to Hywel Dda LHB's good practice in sending out DVDs to every house in Dyfed, but then you said that engagement needs to be a two-way process. Sending out DVDs is not a two-way process. These days, there are more imaginative ways of engaging people in a two-way process. If LHBs want to engage and propose changes to hospital services in their area, are you actively putting pressure on them to go out and talk honestly to people directly in meetings about the need for change? If they are confident that those are the best changes then they need to go out there and sell them. People will listen. They may not agree, but they will listen.

[39] **Mark Drakeford:** Elin has had her three questions. I ask you to answer those three points, Minister, and then I will move on to Rebecca.

[40] **Lesley Griffiths:** I have made it clear that LHBs must deliver within their budgets but that that must not be at the expense of service quality or patient safety. I think that many of the changes that you referred to happened because of problems with recruitment. Services must be safe and so these were operational decisions taken by the LHBs. The main reason for several of the changes across Wales was recruitment problems.

[41] I will move on to your third point on engagement. Hywel Dda LHB is trying to come up with innovative ways of engaging. I am not saying that a DVD is the right way forward for everyone. However, it is a different way of engaging and the LHB deserves praise for looking at innovative ways of engaging. I am actively pursuing this with the chairs, and I will pass over to David in a moment, because he is doing the same with the chief executives. I think that you are right about explaining to patients that they will have better outcomes, or that services will be safer, if the change happens. While, as you say, you will not please all of the people all of the time and they are not all going to agree, if they understand, then you are part way there. That is one of the reasons for upping their engagement to levels that we have not seen before.

[42] On capital, I am still making announcements. Last week, I was at the Cardiff Royal Infirmary, where I announced just under £16 million for proposals on GP access and an improved sexual health clinic. Those proposals fit in with the service change plans. You are right that, because there has been a delay, obviously we cannot not make announcements. However, they have to prove to me, within the business case, that the proposals fit in with the service change plans. Just before Christmas, I announced just under £64 million for the children's hospital. So, capital projects are still going ahead.

[43] **Mr Sissling:** On the issue of salami slicing, I confirm strongly that the message to the service is not to do that. We want to control resources in a way that is aligned with good-quality care. Our experience and evidence is that good-quality care, more often than not, represents best use of resources. Reducing hospital-acquired infections, re-admissions, the length of stay and unnecessary admissions means a better patient experience, better outcomes and better use of money.

[44] For example, with regard to the workforce, we are trying to control spend on agency staff, premium rates and sickness levels. What we are not doing is bearing down on front-line clinical staff. In fact, the most recent numbers show that there was an increase in doctors and nurses in September 2011 compared with September 2010. However, there has been a reduction in administrative staff, which is the right approach. That is the kind of approach that



we are adopting. Quality is central, and we aim to maintain quality and not to compromise on it. I confirm and underline what the Minister said on engagement. We know that our plans will only be taken forward if we get the engagement right, and engagement means listening as well as talking. The emphasis at the moment is very much on listening. We need to get the benefit of the views of our clinical staff, stakeholders, local communities and individuals and to listen to them respectfully and be prepared to amend and adjust our plans in light of what we hear.

[45] **Rebecca Evans:** I would like to move on to look at recruitment issues in the NHS. You acknowledge in your report that there is a serious recruitment issue, particularly in speciality grades and certain geographical areas. Minister, you will be aware of the temporary closure of the minor injury units at Tenby and South Pembrokeshire hospitals so that staff could be redeployed to keep the accident and emergency unit at Withybush Hospital open. Could you expand on how you are addressing the urgent and pressing need for recruitment in the NHS?

[46] **Lesley Griffiths:** I have been reassured that the closure of the minor injury units that you mentioned is only temporary and that it is not part of the service change plans—it is about recruitment difficulties. There are difficulties with recruitment across the UK, and we are not immune from them in Wales. As David mentioned, we have 1,500 more staff working in the NHS in Wales now than were working in the NHS in Wales in 2007, and that includes 222 consultants. So, we are attracting recruits, but there are specific specialties and specific geographical areas in Wales where we are experiencing difficulties.

[47] Next Wednesday, 1 February, the First Minister and I will be launching a recruitment campaign, which we hope will help; it is something that we have been thinking about since October. That does not mean that work has not been carrying on in the meantime. We need to do more with medical schools, for instance—we need to get out to medical schools to show them that Wales is the place to come to pursue your career. It is another reason why we have to remodel our services: to make it a more attractive place, so that when a doctor is looking at forwarding his or her career, they can come here to do that.

[48] The marketing campaign will run for 12 to 18 months and it will be staged, and, as I said, it will start next week. We have a new strapline—‘Work for Wales—the next step for your medical career’, and we will be launching a website with all the information about vacancies and recruitment issues. The site will go live on Monday, and the First Minister and I will launch it on Wednesday. This will fit in with all the other work that health boards and trusts have been doing. We will also have a range of advertisements running in the *British Medical Journal*—the first advertisement is due to go in at the end of the next week or the beginning of the following week.

[49] **Mark Drakeford:** Kirsty wants to ask to a specific question on the staffing issues.

[50] **Kirsty Williams:** Could you give the committee an update on the current number of vacancies for hospital doctors and their grades? On average, how long are those vacancies held open? Have you done any analysis of whether those vacancies are as a result of failure to recruit following advertisement, or whether there is a freeze on advertising by local health boards? With regards to your marketing campaign, what monitoring processes will you put in place to assess the worth of that campaign? How many doctors do you expect to recruit as a result of that campaign?

[51] **Lesley Griffiths:** I have a table here of the vacancies as at December 2011. It would probably be more helpful if I were to issue the table to you rather than to go through it column by column now. There is no freeze on advertising by local health boards, but I will bring in David on the question of whether vacancies remain following advertising.

[52] In relation to the recruitment campaign, I have asked the reference group to give me some criteria so that I can measure how successful the campaign is as we go through the 18 months. We need success criteria so that we can assess effectively how successful the campaign is as we go through the different stages.

[53] **Kirsty Williams:** I know that we need criteria, but it would be interesting to know what they are.

[54] **Lesley Griffiths:** It is something that we are putting together at the moment, before the launch of the campaign next week. I will send a note to the committee on that.

[55] **Kirsty Williams:** It would also be useful to have details in the note of how much the campaign will cost.

[56] **Lesley Griffiths:** I can tell you how much the budget is; it is between £70,000 and £80,000. David, do you want to talk about LHBs?

10.00 a.m.

[57] **Mr Sissling:** In terms of some of the recruitment processes for doctors, there are particular specialties where there are acute recruitment difficulties, such as paediatrics, elements of medicine and aspects of mental health care. Like other parts of the UK, we are not always able to recruit. In some cases, we have advertised and done due process, but applicants have been unsuccessful. We have also failed to attract sufficient candidates for jobs. At times, we have failed to attract sufficient high-quality candidates—we need to attract high-quality candidates, to ensure that we do not lower standards. We have re-advertised and re-advertised in some cases, and I hear descriptions of multiple adverts failing to produce results. We are now thinking differently in some cases about what we need to do to secure a sustainable workforce in the NHS in Wales.

[58] **Dr Jones:** I chair a junior doctor review group, with all the major stakeholders around the table, in collaboration with the British Medical Association. Our remit is to try to do what we can to make Wales more attractive. So, we have maintained free accommodation for F1s; we have reviewed the quality of hospital accommodation; we have produced information and literature for people coming here so that they understand the NHS in Wales; and we have a much higher presence at UK recruitment meetings for doctors. Arguably, it is difficult because some of our services are intrinsically unattractive. Doctors want to go where there is a very good training environment—they want to go to places where there are rotas with lots of doctors, so that they are not asked to fill gaps at the last minute, where there is time for training and structured education, and where there is clinical support available. This is an important feature of the service change requirement: we need services that are more intrinsically attractive for training purposes. That would be a much more fundamental, long-term approach to this. However, I am assured that there is no freezing of recruitment. Sometimes it takes time to get an application for a new consultant post when someone is leaving or retiring—there is quite a long process of approval and so on—but no-one is going to freeze posts in clinical areas where we need to improve the quality of clinical services and where that is not happening.

[59] **Lesley Griffiths:** I have done a quick add-up: it is about 200 at all grades across medical and dental vacancies, from foundation 1 right up to consultant. I will ensure that you get a copy of this table.

[60] **Mark Drakeford:** Staffing is a really important issue, so I am going to allow a few more questions from Members on this.

[61] **Rebecca Evans:** You refer in your paper, Minister, to the National Leadership and Innovation Agency for Healthcare software model to compare anticipated future supply against demand for newly trained consultants. What has that software found and how are you using it to inform your plans for the NHS? Also, we have not touched on nursing staffing yet. What are your plans to increase the number of nurses in the NHS in Wales?

[62] **Lesley Griffiths:** The NLIAH model, to date, suggests that most specialities will have consultant GP vacancies. Our new certificate of completion of training holds the numbers broadly in balance over the next five to 10 years. The modelling work is presently indicating a likely Wales-wide shortage in the areas of general practice, consultant posts that are not sufficiently attractive to draw enough quality applicants, and specialities that experience a sudden increase in demand. However, these are early indications and they could change as we follow the data over the next few months.

[63] Nursing numbers have increased. I do not have any plans to do anything specifically about nursing, because I am quite happy with the nursing numbers that are coming through. NLIAH advises me on numbers, but, at the moment, there is no shortage.

[64] **Vaughan Gething:** I will pick up the point that you mention in paragraph 33 of your evidence, where you refer to a reduction in the number of doctors due to the UK Government's new immigration rules. I am interested in whether you can quantify the extent to which that exacerbates the recruitment problems, and whether that is a general issue, or whether it affects certain grades and types of recruitment.

[65] **Lesley Griffiths:** I do not think that it affects certain specialities, but the immigration policy has certainly had an adverse affect on recruitment in Wales.

[66] **Vaughan Gething:** Is there anything on the extent of it? I know that you say that it exacerbates the situation, but I am interested in whether you are saying that you can anticipate a certain level, and then beyond that you say that immigration has an effect, although you cannot quantify that in more detail.

[67] **Dr Jones:** That is a difficult question to answer. Changes occurred around four or five years ago. We need to do some quite sophisticated work to have a look at how the pattern of vacancies in Wales and across the UK changed around that time, but even then it would be difficult to be clear about its specific contribution. However, just from everyday experience, it really did make a big difference: a lot of posts that UK graduates may have found less attractive, because they were further away from urban areas, were often filled by people who came from outside, as those posts represented good training opportunities compared with what they could get at home. So, it is a difficult question to answer.

[68] **Lesley Griffiths:** One area that we could look at is the European Union, because I think that we could recruit much more from the EU. The numbers that we have been getting from the EU are very limited. I have asked officials to look positively at recruiting more from the EU.

[69] **Vaughan Gething:** Given the recruitment difficulty that we already face, have you made any assessment of how that could be further exacerbated if there were different pay systems for NHS staff across the UK? We know that the Chancellor has written to NHS bodies to look at regional pay. Can you anticipate how much that would hinder recruitment in Wales?

[70] **Lesley Griffiths:** I do not think that I am the only Welsh Minister who is concerned about regional pay; we would resist any such move. It would have a very adverse impact on

recruitment if, for example, people in Cardiff were paid more than people in Wrexham. That would have a very adverse effect on the NHS.

[71] **Elin Jones:** Junior doctor training, as mentioned by Dr Chris Jones, is important in order to ensure an adequate workforce in the future, but junior doctor training is linked to accident and emergency departments in particular. There are a number of key decisions that may well be taken by local health boards in south and west Wales on the location of accident and emergency facilities in the future, although they will not be taken until later this year. Can you confirm that the delay on those decisions will not delay the planning of junior doctor training in hospitals in south and west Wales, and possibly in north Wales, too?

[72] **Dr Jones:** I agree that the quality of training that we offer doctors in Wales is important, because that is what attracts people from the UK into Wales—so that they can stay in Wales to complete their long-term careers here. The deanery is very highly regarded and strongly represents the case for improved quality of training. We support it entirely in that and work closely with it. There are some pressing areas, in particular paediatrics, which is a difficult area. We know that there will have to be some change in that area sooner rather than later to enable doctors to go into services, because the training is acceptable. However, our commitment to the quality of training is unaffected by the timing of service change plans, but the service change plans will be a vehicle for improving the quality of training.

[73] **Mark Drakeford:** We have had a good run on staffing, so thank you all for your questions on that.

[74] **William Graham:** I commend your commitment, Minister, to the Flying Start programme, which is a really good scheme with tangible outcomes. I am grateful that you are devoting so much money to that. However, my question relates once again to the capital allocation. We know that your budget is severely constrained and you will anticipate that my question is about the critical care centre at Llanfrechfa. How is that progressing? I appreciate that there is a problem with the capital not being available, but that has a knock-on effect, as you will well know, both on the Royal Gwent Hospital and on the Nevill Hall Hospital. What could be better—particularly building on what Dr Chris Jones said about recruitment—than having a critical care centre of that kind? Furthermore, you said that you are not allowing salami-slicing, but we know that the Aneurin Bevan Local Health Board has already closed its minor ailments units, which will once again impact on the accident and emergency units at the Royal Gwent Hospital and Nevill Hall Hospital.

[75] **Lesley Griffiths:** In relation to the critical care centre, we have asked the local health board to put forward the business case again, and it has said that that will not be done until the end of December. Just before Christmas—it was probably in December, but it may have been in November—it put in a case for funding of £4 million to take the business case forward; I agreed to that funding and the LHB has had that money. We should have the business case by the end of this year.

[76] You are talking about operational matters. I do not want to see salami-slicing, and I want to see financial targets being reached, but I have said that that cannot be at the cost of quality and delivery of service. We have to accept that we will not have everything everywhere that we want. These are operational decisions for the LHBs.

[77] **William Graham:** My second question relates to the electronic referral service, which is a welcome innovation. Will you give us some idea of how you anticipate that it will be measured? We do not want to return to a situation where all these things go well with regard to hospital organisation but patients or their relatives have to ring up on the day to ask whether a bed is available.

[78] **Lesley Griffiths:** Sorry, William—will you repeat the question?

[79] **William Graham:** How will you monitor how the electronic referral service works, and whether it is successful or unsuccessful for patients? The community health council will have a substantial role in that regard. I am asking you to assure us that we will not have a situation where all is agreed with regard to the hospital but patients or their relatives have to ring the hospital on the day to ask whether a bed is available.

[80] **Mr Sissling:** The electronic referral system works for out-patient appointments. More than 50% of GPs are now using it, and we want to develop it. Much of the evaluation has to depend on the views of the clinicians involved—they are at the heart of this; it is a clinical system for clinicians. Our clinicians will be very keen to advise us of any problems. Thus far, we have not had feedback about problems; it is quite the opposite, as they find it a much more convenient system to use.

[81] It goes alongside the My Health Online system, which is the means by which patients can make direct appointments with their GP practices and get repeat prescriptions. That is now being rolled out to a point at which it will be available for all practices by autumn of this year. Again, subject to detailed evaluation, we are getting positive feedback from patients who say that it is a clear design to improve their interaction with the NHS. The evaluation will continue. We want to ensure that the investment of time, effort and energy is translated into good outcomes, better use of resources and better clinical flows. Ultimately, we would want to put patient experience at the heart of how we measure effectiveness and the experience of the NHS.

[82] **Lesley Griffiths:** A few weeks ago, I gave evidence, and Gwyn Thomas, the chief information officer, was here. Gwyn said that the technology is there but that it is just a matter of bringing it all together. Certainly, there seem to be too many systems across the NHS. It would be much more successful if we brought them together, and that is the approach that we are taking. You may be aware of the Welsh clinical portal, which, from spring of this year, all hospitals will have to implement. It puts all the information about a patient in one place, which will be very beneficial. I used to work in the NHS, and I used to scurry around the hospital looking for medical records. This will become the focus, and it will benefit the patient in the longer term.

[83] **Mark Drakeford:** Mick had a point following on from one of William's questions. I will then go to Lynne, before thinking about how we use the rest of the time.

[84] **Mick Antoniw:** My point has been dealt with, but I have another issue to come to in a minute.

[85] **Lynne Neagle:** I wanted to raise the capital situation, especially in relation to the specialist and critical care centre. I am grateful for the meetings that you have had with me about it, Minister. My understanding of the situation in Gwent is that things are very much proceeding on the basis that this hospital will become a reality. You have said that you have been able to make some announcements, for instance in Cardiff, where the plans fitted with your idea of service change. I am confident that what is planned for Gwent is very much in that mode. I wanted to ask for assurances that you have put money aside somewhere in the capital budget, because these announcements were made and people are expecting them to come on stream.

10.15 a.m.

[86] **Lesley Griffiths:** As I said, it is subject to the business case; nothing can be done before that is submitted. I have given them the money to take that issue forward, and we will

have to look at our capital projects. You are aware that we have had a 40% reduction in our capital budget, but I can assure you that we are looking closely at that. However, until the business case comes at the end of the year, I cannot give any commitment.

[87] **Lynne Neagle:** I have two other questions on mental health. Can you say a little more about how the national partnership board for mental health will work and also when you expect the review of psychological therapies to be published?

[88] **Lesley Griffiths:** The national partnership board will emerge from the mental health programme board, which has now been stood down. You will be aware that a huge amount of work is being done around mental health with the strategy and the Measure, embedding them together. The mental health programme board was stood down because members agreed that its main objectives had been met, but it was decided that a case remained for the maintenance of a multisectoral national group with the capacity and expertise that would be required to influence policy. So, the national partnership board will be that new group. It will be chaired by a Welsh Government official and it will provide an opportunity for members to influence thinking. It will have a key role in overseeing and in implementing the strategy that is now emerging.

[89] In relation to psychological therapies, you will be aware that it was a manifesto commitment, and it is in our programme for government, that I will undertake a review of access to psychological therapies in Wales this year.

[90] **Mark Drakeford:** We have about 10 minutes left. Two Members have only asked follow-up questions to questions that other Members have asked, so I will offer them the first chances in the time that we have left. I will go to you first, Kirsty, and then to Mick.

[91] **Kirsty Williams:** To go back briefly to Flying Start, can you outline the commitment to increase the number of health visitors to deliver on your manifesto commitment that you will double the number of children who are targeted by this programme and whether you are confident that the capacity exists within the health visiting service to meet that?

[92] Secondly, on my favourite, the over-50s health checks, it says in your paper,

[93] ‘When I have decided what the approach should be, it will be implemented from 2013-16.’

[94] This was the headline health commitment in the Labour Party’s manifesto. Can you outline, on coming to office, what level of development work had been undertaken that allowed you and your colleagues to make such an assertion? Can you outline, at this early stage, who you believe will carry out these health checks? Will it be GPs or practice nurses? In the paper that we had recently about community pharmacies, there was a suggestion that these health checks would be carried out by community pharmacists. Can you tell us now who you envisage carrying out these health checks?

[95] **Lesley Griffiths:** I will start with Flying Start. I am confident that we have the capacity, and officials are working closely on this. As you will be aware, we have made available a total of £55 million of revenue funding over the next three years and also £6 million of capital funding. I know that the Deputy Minister is working closely to look at which buildings could be used without building new buildings in the first instance, before we commit the capital funding—

[96] **Kirsty Williams:** Is it your plan to increase the number of health visitors working in this programme, and if so, by how many?

[97] **Lesley Griffiths:** I do not have the exact figure; I will have to send you a note on that, but yes, we will be increasing—

[98] **Mr Sissling:** Due to the nature of the programme, it is very much driven by the number of children. So, doubling the number of children receiving the benefit of the programme means virtually doubling the number of health visitors. That means a major recruitment programme and training programme, because we do not want to meet Flying Start requirements from elsewhere. So, there will be considerable work over the coming months and, probably, over the next year or two—it is of that level of significance—to retrain staff, provide training for existing staff and recruit new staff into this area.

[99] **Lesley Griffiths:** In relation to the over-50s health checks, you are quite right that, at the moment, we are focused on preparatory work. We are looking at the evidence base and at health check models elsewhere; you will be aware that health check programmes are in operation in both England and Scotland, so we are looking closely at those. I want to make sure that the programme complements and builds on other relevant work around public health. You asked who will be doing it; I envisage all those professions that you mentioned being involved—general practitioners, practice nurses and community pharmacists. You may be aware that I said that I want every consultation to be a public health consultation, and that also fits in. I think that we are looking at innovative ways in which we can introduce that. You are right: we are doing the preparatory work. We will not be bringing it in until 2013. I welcome the wide range of views on this issue and I think that we need to consider all views during the development phase. There will obviously be opportunities for stakeholders to contribute to the process as we go through.

[100] **Mick Antoniw:** On the issue of Poly Implant Prothese and the breast implant statement that you made, to my mind, some serious matters of principle arise, and I would like to explore those. I have a couple of follow-up questions on that. Would you first outline the matter of principle, the rationale behind your decision? It is one that I support, but it is important that we look behind it a bit further.

[101] **Lesley Griffiths:** It has been welcomed by most people and in most quarters. My strong belief is that the NHS is there for anybody who becomes ill, however they become ill. These women had the implants thinking that they were safe, and subsequently they were found not to be. There are lots of questions that arise—we only have to look at the role of the Medicines and Healthcare Regulator Agency, which seems to be a very reactive organisation rather than a proactive one. I have subsequently written to Andrew Lansley, questioning the regulation, questioning the organisation and pointing out that we have a surgical materials testing laboratory in Bridgend—Wales is the only place in the UK that has one. I have also written to Nicola Sturgeon and Edwin Poots in Scotland and Northern Ireland to see if they would like to use it. Here we have an organisation that actually goes into hospitals, takes surgical devices off the shelves and tests them—it is a very proactive organisation.

[102] We must remember that, at the moment, there is still no clinical evidence that these implants need to be removed. However, private providers do have a duty of care. I will pass over to Dr Jones in a moment, because I know that he is talking to private providers. If any woman is concerned—and I really regret the concern—they should make an appointment with either their surgeon or their GP, and have an assessment. If they are then found to need removal and replacement, that is what we will do on the NHS. We are not letting private providers off the hook. I know people think that that is the case, but we are not. In fact, we are trying to make sure that they fulfil their duty of care and, as I said, Dr Jones is meeting with them. We know that there are no private providers in Wales that have used the PIP implants, and we know that they have not been used in the NHS, so we think that the figure is very low, but our priority is to find out what that figure is. I know that Dr Jones has done a lot of work on that.

[103] **Mick Antoniw:** Just following on, there are two points in particular that arise from that. I will ask them separately. First, unless people who are receiving treatment sign their legal rights over to us, how on earth are we going to be able to pursue the private sector, which should be taking responsibility, and from whom we should be recovering the costs? What legal steps are you taking to ensure that the Welsh Government is in a position, where this arises, to recover these costs?

[104] **Lesley Griffiths:** We have instructed a barrister. I have to be careful in what I say, because I do not want to prejudice the case—as a lawyer, you will appreciate that. The NHS cost recovery scheme is one area that we can pursue. You are talking about us asking patients to sign to say that the Welsh Government can pursue this, but we cannot compel people to do that. I would think that if a woman were in that position, she would be pretty unhappy with her private provider and would be keen for us to pursue that. Within the pathway that we have set out, women would need to provide written evidence that they have PIP, not that they just think that it is a PIP implant. They would also have to prove to us that their private provider will not fulfil its duty of care.

[105] **Mick Antoniw:** I would like to follow up that point, as a very important point arises from it. With joints, for example, there is a register, which means that you know where the replacement has come from and what type it is, and you can follow the path, analyse the failure rate and so on. With the particular PIP products, there has been a gross failure. It seems that that is why no-one knows how many have been implanted, where they are, or the particular type involved. It has almost been a fraud that has resulted in the closure of the company for a second time. However, there seems to be a gross dereliction and a gross failure on the part of the regulatory scheme. It is not a devolved scheme; we are part of it. What measures or proposals do you think we should be considering, not just with regard to this particular medical device, but others, in order to ensure that there is a fit-for-purpose regulatory regime that applies in Wales? If we do not do that, such an issue will arise again—if not with this type, then with another type of provision.

[106] **Lesley Griffiths:** As I said, I have written to Andrew Lansley about the regulation, because you are quite right to say that it is not devolved and it is something that needs to be looked at. This situation has thrown the issue into the open. I will pass you over to Dr Jones, who can say a bit more about the specifics.

[107] **Dr Jones:** Sir Bruce Keogh, my counterpart in England, is leading work to look at the regulatory environment. That is all-UK work, as evidenced by the fact that the Welsh patients with these implants had them fitted in England. We are very keen to be a part of that process. You mentioned a register; some years ago, there was a register, but it disappeared gradually, I think. However, that is being considered again and it would be an all-UK commitment and would have some merit. We are expressing a wish to be involved in the further work that needs to be done, but there has been a regulatory failure.

[108] **Mick Antoniw:** I presume that you will report back on any progress made in this regard.

[109] **Lesley Griffiths:** Yes, I will do so.

[110] **Mark Drakeford:** Minister, I am going to allow the shadow Minister for health under the wire to ask one final follow-up question.

[111] **Darren Millar:** You will be pleased to know that my question is not on this particular issue, Minister. Two things were omitted from your written paper about which I would appreciate an update, and I am in no doubt that other Members would also take an



interest in these issues. The first is wheelchair services. The committee, in the previous Assembly, undertook a report on wheelchair services and there is some evidence, although it is patchy in parts of the country, that there has been a recent deterioration in that service. The second matter is mental health services for veterans. You will be aware that there has been some concern about post-traumatic stress disorder services for veterans for some time in Wales. There is no doubt that there have been improvements in the availability of such services and access to them. However, the committee has not received any detailed information on that particular issue. Once again, it has been subject to a committee report in the past. I know that time is short now, but perhaps some written information would be useful.

[112] **Lesley Griffiths:** In relation to wheelchair services, we have invested heavily in those, particularly in Betsi Cadwaladr University Local Health Board, for example. The money has been spent on employing staff to get the waiting times down. There has been an improvement in that respect.

[113] In relation to veterans, we have invested £485,000 in our mental health and wellbeing service for veterans, which was launched in October 2010 following a pilot scheme in Cardiff and Vale University Local Health Board. It is unique in the UK; it provides local access to specialist outpatient care for veterans and also signposts other support if veterans need it, such as treatment for substance misuse. You will also be aware that we have veterans health champions in all local health board areas, who play a key role in developing the service.

[114] **Mark Drakeford:** Minister, I thank you and your officials very much indeed for answering such a wide range of questions this morning. We had a substantial go at two of the big issues in terms of budgets and staffing, but you have answered questions on a far wider range of topics. Thank you for your offer of additional written material. As Darren said, those last questions did not appear in your original report and we rushed through them a little, but if there is anything that you want to add on those points, we would be very glad to have that information, too. If there is anything that we have not asked you or if there is something that you think we really ought to know before the session winds up, we have around 30 seconds left if you want to say anything.

[115] **Lesley Griffiths:** No, that is fine, thank you very much.

[116] **Mark Drakeford:** Diolch yn fawr **Mark Drakeford:** Thank you very much. iawn i chi. Cawn egwyl o 10 munud cyn y We will take a 10-minute break before the sesiwn nesaf. next session.

*Gohiriwyd y cyfarfod rhwng 10.30 a.m. ac 10.40 a.m.  
The meeting adjourned between 10.30 a.m. and 10.40 a.m.*

### **Blaenraglen Waith y Pwyllgor: Materion yr UE Committee Forward Work Programme: EU Matters**

[117] **Mark Drakeford:** You will remember that we had a brief discussion of these matters before Christmas, when Gregg was with us by video link. Some of us met last week with the Presiding Officer, who is very keen for committees to take seriously their new responsibilities to keep an eye on EU-related policy developments within their remits. What we did before Christmas was to take a quick look at a range of potential ways in which the committee might discharge its responsibilities. We have papers on the issues that were discussed then. I would now like to give Members an opportunity to raise questions with Gregg about the information that we now have. After that, we probably need to decide whether we want to take forward any of the potential areas that we could consider in our forward work programme.

[118] First of all, there is a series of papers—papers 2, 3, 4 and 5—all of which refer to the discussion that we had earlier and to some further work that has come out of that. So, if anyone wants to check anything in those papers with Gregg first, we will do that.

[119] **William Graham:** Gregg, do you have an update on the health strategy?

[120] **Mr Jones:** No, not yet.

[121] **William Graham:** Do we anticipate at all when that will be available?

[122] **Mr Jones:** The current one runs out in 2013, which means that they must be preparing one. You would certainly expect them to be doing that this year. I can check again.

[123] **William Graham:** So far, there is nothing.

[124] **Mr Jones:** No.

[125] **Vaughan Gething:** I am interested in the points about the modernisation of the professional qualifications directive and the working time directive, and some of the talk behind that. Before I became an AM, I ran cases on the working time directive, and I am quite familiar with the idea of working time and the definition of that, and where we may or may not get to. Clearly, working time has a significant impact on the organisation of health and care services as well. Much of the focus was on health services, but this issue has a huge impact on care services, too, and in particular on residential wardens and the organisation of those services. I would be interested in what you think is likely to happen. I appreciate that the matter did not progress, because the Council and the Parliament could not agree on how to move matters forward.

[126] Equally, I would be interested in the perspective on the modernisation of the professional qualifications directive. Being relatively objective, I am interested in whether that is seriously about protecting patients and the quality of professionals, or whether it is simply about protecting professionals in each of the European states.

[127] **Mr Jones:** On the working time directive, you are absolutely right; it is a controversial dossier. I think that it was the first one that failed at its Third Reading, which is the conciliation phase. It failed because there was a blocking minority in Council, including the UK, which felt that the status quo—there is already working time directive in place—was better than the Commission's proposals. It was featured in the 2010 Commission work programme, but proposals did not come forward. I think that it was also mentioned in the 2011 work programme, but proposals did not come forward then, either. It is not even mentioned in the 2012 work programme, because there are still problems. From the point of view of the member states that originally had issues with the proposed changes, the Commission has not addressed those concerns, so they do not feel that it is feasible at the moment to come forward with new proposals.

[128] You are absolutely right; it was around the definition of working time and how you consider on-call time, and whether non-worked on-call time counts towards the 48-hour limit. Also, fire services had some grave concerns about that. So, with that one, it is a matter of wait and see. The impression that I get from talking informally to colleagues who are doing work on the dossier is that they do not see much evidence that it will progress at the moment. So, watch this space.

10.45 a.m.

[129] On the modernisation of the professional qualifications directive, proposals came out

just before Christmas. I am waiting for the UK Government's explanatory memorandum on that, because it will be interesting to see its take on this. The UK Government prepares explanatory memoranda on all legislative issues that come out of Brussels. I would prefer to give you a note on that, as I did with the other directive, because it is a public meeting and I do not want to say anything silly—

[130] **Vaughan Gething:** That does not stop Members. [*Laughter.*]

[131] **Mr Jones:** It is driven by single-market issues; the main thrust of the EU's overarching aim at the moment is about economic drivers. So, I would couch it in those terms. The NHS has a European office based in Brussels, and that is one of its top issues. It is looking at it from the point of view of health professionals, which is an issue that you discussed earlier in this session with the Minister. I ticked that one off in my head when I heard that discussion.

[132] **Mark Drakeford:** Yes, it was interesting to hear the Minister say that. We are still looking at points of clarification on the papers that we have. Lynne and Mick have questions on this.

[133] **Lynne Neagle:** The paper on models of ownership for residential care is very interesting, particularly the table comparing other European countries, which seem to have a much higher level of public or not-for-profit ownership than the UK. It would be useful if we could have some more information on that for our inquiry.

[134] **Mark Drakeford:** We will talk in a couple of minutes about the future work that we might want to do, but I will anticipate it by saying that my feeling is that a more sensible use of our time would be to spend a bit of time during our inquiry on residential care on whether there are lessons that we can learn from other parts of Europe. The paper that we already have is very interesting in that regard.

[135] **Mick Antoniw:** I have two quick points on that. I thought that the paper was excellent, because it gives us a picture that we can work on. I do not want to follow in the footsteps of Mohammad Asghar in travelling to America, but one or two countries look incredibly interesting in terms of how the mixed provision is operating, particularly with regard to its connection with the state. Would it be beneficial to look at whether public or not-for-profit provision exists more locally? In addition, would it be worth visiting one of these places to see how that operates, provided that there would be a substantive learning experience from it?

[136] I have a second question that I will ask separately.

[137] **Mark Drakeford:** Okay; I will ask people to have a think about that point. If we were to agree that we will take European issues forward over the next few months mainly by taking an interest in how residential care services are provided in other parts of the EU, paper 5 has a table, which Lynne referred to, showing that in the Netherlands, for example, 80% of long-term care provision for older people is provided by the not-for-profit sector. Italy also has a substantial proportion of that. There are a number of different ways in which we could think of pursuing that when we receive more information from Gregg.

[138] I guess that most members of the committee will have seen a note that Julie Morgan and Chris Chapman distributed. They are using the facility available to individual Members—rather than committees—to make one visit a year to a European capital where that visit is connected with work that they are doing. They are both going to Finland—I think that other Members are joining them—to follow up some work that the Children and Young People Committee is doing. So, that is a possibility. There is also a possibility for us to go in a

committee capacity.

[139] **Darren Millar:** It would be useful to glean more information about how the system works in some other countries. I am fascinated by the graphs. I want to check something with you, Gregg. The first graph, which shows percentages of private care, just has a dot for England. Is that for the UK as a whole, or does it just represent England?

[140] **Mr Jones:** I will have to check that, because the paper was written by Gareth Thomas. He did the work, but we can clarify that.

[141] **Darren Millar:** I was just interested to know. In the graph, not all countries represented in figure 2 are in figure 1. I wondered whether the other information might be available for the others. I am particularly interested in Germany and the Netherlands. Germany appears to have a much more balanced approach: a smaller proportion of care provided by the public sector than in the UK, but a huge whack of not-for-profit organisations and private sector provision on top. Those two, in particular, look interesting.

[142] **Lindsay Whittle:** I wonder whether the National Assembly could utilise its benefits with the partnership council, with the WLGA, because every local authority in Wales is twinned with other places in Europe—most of them with a town in Germany. We could be overloaded with information from Germany. Lots of them are twinned with places in other countries as well. There are regular visits every year. I have been party to those visits. Joe Public thinks that they are a bit of a jolly—we do have good times, but hard work is also an integral part of those visits. I was particularly interested last year when we went to Ludwigsburg in Germany, where we spoke about how that city handled its waste and the energy from it. That was useful. There must be examples of interest at this committee. We could ask the WLGA to use its good offices to feed that information back to us as well. It is a good example of national Government in Wales asking local government to work with us. I think that that is what they are looking for.

[143] **Mark Drakeford:** That is a useful point. I will make sure, through Llinos, that we tap into whatever help, advice and information we might be able to get through the WLGA and those contacts that are already there. Gregg, we would be grateful if you were able to pursue the points that Darren was asking about. If it is an England-only illustration in the first figure, I would be interested to know whether the pattern in Scotland is substantially different. My guess is that England and Wales are not very different, because a lot of this is driven by social security legislation, which tends to drive policy in the same direction. However, if Scotland were to have a different mix, that would be interesting.

[144] **Darren Millar:** I think also that the situation in Northern Ireland might be interesting to look at, because there are joint health and social service boards in Northern Ireland. I do not know whether that has an impact on how things are provided. Committees in the third Assembly would, occasionally, pay a visit to these places in order to gather information. That may be useful, but then again, it may not be. We may be able to do things via video-conferencing. Sometimes, immersion in those settings and finding out about pathways to care can only be done by being on the ground and spending time in these places.

[145] **Mark Drakeford:** This is how I see us doing it. Today, we are piling up requests for extra information so that we have a better idea of what the map looks like and where the points of interest might be. If, when we have done that, we think that there is a clear case for some visits to be made, we will come back to it and look at it positively, if we are convinced. However, we will only do it if there is a clear work benefit to be derived from it. The Presiding Officer, at the meeting that we had with her last week, was keen that committees should consider making visits outside the Assembly and Wales, where we are clear that there is a contribution to be made to the discussions that we are having.

[146] **Mick Antoniw:** I am interested not only in the way that works in Wales and the extent to which that is operated, but in the access to health services abroad. There are a lot of people from Wales who live wholly or partly abroad and who travel and so on. I have come across many examples of people who are having difficulty accessing, or who are not accessing, health services or are paying considerable amounts of money or paying for insurance and so on. It seems to me that there is a role we could look at with regard to ensuring that the system is simpler and more understandable, so that people from Wales get access to healthcare in other European countries, when they need it, in accordance with the provisions. Is there some more information we could get on how it works in other countries, whether there are still obstacles and how we can improve the knowledge or access that Welsh citizens have?

[147] **Mr Jones:** A great deal of that is wrapped up in the directive I referred to in the paper on patients' rights and cross-border healthcare. It looks at the information that patients need to have to be able to make informed choices about healthcare options. That was driven by EU legislation catching up with EU case law. There were a number of cases where patients had received treatment outside their member state, whether because they were living somewhere else or had planned treatment abroad, and the courts had ruled that they should have their treatment costs covered by the national healthcare service of their member state. It probably makes sense for me to do a briefing on what the directive requires. There will be a direct bearing on Wales as the devolved powers mean that Wales would be responsible for those elements with regard to patients from Wales travelling abroad as well as patients travelling from abroad for treatments in Wales.

[148] **Mick Antoniw:** That would be helpful and would certainly drive further thought on that.

[149] **Vaughan Gething:** Going back to the point about figure 2 on page 36, showing the split in different models of care, I would be really interested to know some more about the non-profit models that are referred to. There is certainly more than one model, and if there is a predominance of one model or another, either across each of the countries or within each one, I would be really interested to understand that as well. I know that, in Italy, co-operatives and mutuals are part of the sector, but I am not at all clear about what the non-profit model looks like in the Netherlands, where 80% of care is in the non-profit sector. France, Italy and Germany all appear to provide about half of the care in the non-profit sector. I am really interested in how that is organised in that wider definition of non-profit provision.

[150] **Mark Drakeford:** That is a very good point. From memory, so this may not be completely accurate, and to go back to the point Lindsay was making, I believe that, in the Netherlands, a great deal of the not-for-profit provision is municipal provision. So, it is not public, but it is not-for-profit provision driven through municipalities. They take the lead on it.

[151] **Darren Millar:** The other really interesting table in that paper is table 2 at the back of the document. It clusters the countries together by provision. Going back to the other tables, Germany apparently has relatively low levels of public spending in terms of its costs, the Netherlands has high levels of public spending and we are somewhere in the middle. Those two countries in particular may be quite fascinating to us in terms of how to make some provision in Wales.

[152] **Mark Drakeford:** To summarise, this morning, we have had a look at the information available to us as a result of our last discussion. There are some further points arising out of those papers. Gregg, you are going to provide some extra notes for us on those. With regard to actively planning into our work programme a stream that has a direct

connection to European matters, I think that we are saying that we will pursue that over the next six months in our residential care inquiry and that, within that, we are particularly interested in the alternative models of provision we see elsewhere. Gregg is going to get us some more detailed information arising from the paper that we already have. When we have that, and when we have any information that we might be able to get from the Welsh Local Government Association, we will look to see what countries are emerging as particularly interesting. We have already heard that the Netherlands, Germany and possibly some parts of Italy may be worth pursuing. At that point, we will decide how to take that further. We will need more on paper, but there may be a case for looking at some of the alternatives in person. Do Members wish to add anything further on that? I see that they do not.

11.00 a.m.

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

[153] **Mark Drakeford:** Mae gennym gofnodion cyfarfod y pwyllgor ar 11 Ionawr. Nid ydym wedi derbyn unrhyw sylwadau arnynt, felly rydym yn derbyn y cofnodion.

**Mark Drakeford:** We have the minutes of the committee meeting on 11 January. We have not received any comments on them, so we accept the minutes.

[154] Diolch i bawb am heddiw. Bydd aelodau'r pwyllgor yn dod at ei gilydd nesaf ddydd Iau, 2 Chwefror. Mae gennym sesiwn yn y bore gyda swyddogion ar y Bil drafft sgôr hylendid bwyd Cymru, a sesiwn yn y prynhawn ar fynediad i feddyginiaethau gyda'r Athro Phil Routledge, ac fe fydd pobl eraill yn bresennol i'n helpu gyda'n trafodaethau ar y pwnc hwnnw.

I thank you all for today. Committee members will meet next on Thursday, 2 February. We have a morning session with officials on the draft food hygiene rating Wales Bill, and in the afternoon we have a session on access to medicines with Professor Phil Routledge, and others will be present to help us with our discussion on that topic.

*Daeth y cyfarfod i ben am 11.01 a.m.*  
*The meeting ended at 11.01 a.m.*