Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

15/09/2016

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Dr Frank Atherton	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Rebecca Evans Bywgraffiad|Biography	Aelod Cynulliad, Llafur, y Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol Assembly Member, Labour, the Minister for Social Services and Public Health
Vaughan Gething Bywgraffiad|Biography	Aelod Cynulliad, Llafur, Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon Assembly Member, Labour, Cabinet Secretary for Health, Wellbeing and Sport

Dr Andrew Goodall	Cyfarwyddwr Cyffredinol ar gyfer Iechyd a Gwasanaethau Cymdeithasol a Phrif Weithredwr GIG Cymru Director General for Health & Social Services and NHS Wales Chief Executive
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio, Llywodraeth Cymru Director of Social Services and Integration, Welsh Government

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

Sarah Beasley	Clerc Clerk
Stephen Boyce	Y Gwasanaeth Ymchwil Research Service
Sarah Sargent	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 09:15.
The meeting began at 09:15.

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

[1] **Dai Lloyd**: Croeso i chi gyd i gyfarfod cyntaf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon o'r tymor newydd. Gallaf egluro ymhellach bod y cyfarfod yma'n ddwyieithog. Gellir defnyddio'r clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1 neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf atgoffa pobl i ddiffodd eich ffonau symudol—ac mae hynny'n cynnwys y Cadeirydd—ac unrhyw offer electronig arall achos maent yn gallu ymyrryd efo'r systemau

Dai Lloyd: Welcome to you all to the first meeting of the Health, Social Care and Sport Committee of this new term. I can explain further that this meeting is bilingual. You can use the headphones to hear the simultaneous translation from Welsh to English on channel 1 or to better hear contributions in the original language on channel 2. Can I remind people to turn off their mobile phones—and that includes the Chair—and any other electronic equipment because they can interfere with the electronic systems in the

electronig yn y lle yma? Nid ydym yn disgwyl i'r larwm tân ganu, ond os bydd yn canu, dylem i gyd ddilyn cyfarwyddiadau'r tywyswyr a'u dilyn nhw. Gallaf hefyd nodi ein bod wedi derbyn ymddiheuriadau gan Dawn Bowden a bydd Huw Irranca-Davies yn dirprwyo yn ei lle hi. Croeso, Huw, i'r pwyllgor yma.

building? We don't expect a fire alarm, but if it does go off, we should all follow the directions of the ushers and follow them. I can also note that we have received apologies from Dawn Bowden and Huw Irranca-Davies will be substituting on her behalf. Welcome, Huw, to this committee.

09:16

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod ar gyfer Eitemau 3 a 4
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting for Items 3 and 4

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitemau 3 a 4 yn unol â Rheol Sefydlog 17.42(ix).

Motion:

that the committee resolves to exclude the public from the meeting for items 3 and 4 in accordance with Standing Order 17.42(ix).

Cynigiwyd y cynnig.
Motion moved.

[2] **Dai Lloyd:** Eitem 2 yw cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitemau 3 a 4. Rwy'n eich gwahodd i symud mewn i sesiwn breifat ar gyfer y ddwy eitem nesaf i'w trafod, cyn i'r Gweinidog ddod yma am 10 o'r gloch pan fyddwn yn mynd yn ôl at sesiwn gyhoeddus unwaith eto. Rwy'n cymryd nad oes gwrthwynebiad inni fynd mewn i sesiwn breifat yn awr. Diolch yn fawr i chi.

Dai Lloyd: Item 2 is a motion under Standing Order 17.42 to resolve to exclude the public from the meeting for items 3 and 4. I invite you to move into private session for the next two items to be discussed before the Minister attends at 10 o'clock and we will return to a public session after that. I take it that there's no objection to us going into private session now. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 09:17.
The public part of the meeting ended at 09:17.

Ailymgynullodd y pwyllgor yn gyhoeddus am 10:01.
The committee reconvened in public at 10:01.

Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon a Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol—Trafod Blaenoriaethau
Cabinet Secretary for Health, Wellbeing and Sport and Minister for Social Services and Public Health—Discussion of Priorities

[3] **Dai Lloyd**: Croeso yn ôl i chi gyd i'r adran gyhoeddus o'r cyfarfod yma o'r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol a Chwaraeon. Yr eitem nesaf ar yr agenda ydy eitem 5, ac rydym yma i drafod ac i graffu ar waith Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon, ac hefyd y Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol. Rydym yma i drafod eu blaenoriaethau nhw, ac felly, mae'n bleser gen i groesawu, am y tro cyntaf, i'r pwyllgor yma, Vaughan Gething, Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon, ac hefyd, Rebecca Evans, Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol, yn ogystal ag Andrew Goodall, y cyfarwyddwr cyffredinol ar gyfer iechyd a gwasanaethau cymdeithasol a phrif weithredwr y gwasanaeth iechyd gwladol yng Nghymru; Albert Heaney yn ogystal, cyfarwyddwr

Dai Lloyd: Welcome back to you all to the public part of this meeting of the Health, Social Care and Sport Committee. The next item on the agenda is item 5, and we're here to discuss and scrutinise the work of the Cabinet Secretary for Health, Well-being and Sport, and also the Minister for Social Services and Public Health. We're here to discuss their priorities, therefore, it's a pleasure to welcome for the first time, to the committee, Vaughan Gething, Cabinet Secretary for Health, Well-being and Sport, and Rebecca Evans, the Minister for Social Services and Public Health, as well as Andrew Goodall, the director general for health and social services and NHS Wales chief executive; Albert Heaney as well, the director of social services and integration; and also, Frank Atherton, the chief medical officer.

gwasanaethau cymdeithasol ac integreiddio; ac hefyd, Frank Atherton, y prif swyddog meddygol.

[4] Felly, sesiwn graffu ydy hon, ac rwy'n bwriadu mynd yn syth i mewn i graffu gyda 'bore da' i'r Gweinidog ac, fel Cadeirydd, mi wnaf ofyn y cwestiwn cyntaf. A allwch chi ddylunio eich blaenoriaethau a'ch disgwyliadau, fel Ysgrifennydd y Cabinet dros iechyd, ar gyfer y pumed Cynulliad? Diolch yn fawr.

Therefore, this is a scrutiny session, and I intend to go straight into scrutiny with a 'good morning' to the Minister and, as Chair, I'll ask the first question. Can you outline your priorities and expectations, as the Cabinet Secretary for health, for the fifth Assembly? Thank you.

[5] **The Cabinet Secretary for Health, Well-being and Sport (Vaughan Gething):** Thank you for the introduction and the opportunity to meet you at the start of the term, with the committee being in session. I'm happy to set out what I hope will be a fairly consistent message with those that I gave shortly after I was appointed. The context in which the health service operates is obviously important. That context is rising demand and complexity: so, more coming through the door. It's also a context of real and undeniable financial challenge. That's an issue across public services right across the UK. We can have arguments about why that is, but it's an unavoidable reality. So, it's therefore about how we meet that demand with less money, and, at the same time, a growing realisation and acceptance, which I think was helpfully set out yesterday in the debate, that we need new and different models of care. So, it's partly about the workforce, but it's actually about asking, 'What models of care do we need to be able to deliver against that rising tide of demand?' That is, bearing in mind that we will have, overall in public services, less money.

[6] The public service point is important because, regardless of the budget context, we know that part of the change that we need to see is not just service reconfiguration, talking about hospitals, but a broader change in the way that we do our business in health, so within the relationship between primary and secondary care—more services being dealt with and delivered within the community, and not in a hospital setting—and, at the same time, integration with care services, but also with other parts of the public service as well. So, we need to do more in a more joined up and constructive way, for example, with housing and education as well. So, those big challenges around integration really matter, because, ultimately, our priorities are to not

compromise on quality, to deliver better outcomes, and that means a different way of working.

[7] So, not just doing the same things in a different way; it will require us to do different things as well. So, those really big, if you like, broad balancing themes set the context for where we are. My expectations for the service are that we need to be able to confront and take on some really difficult challenges, and I want those to take place in the earlier part of this term, because I think it's important that that debate isn't one that we leave. It isn't really about election cycles, it's actually about the ability to change where we've got control, what we can do and having this whole term to be able to deliver some of that change.

[8] Part of what I'd be really interested in this committee taking a perspective on is being part of a really mature and constructive debate about the future of health and care services in Wales. Part of the difficulty we have seen previously is in the fact that, when difficult choices are made, there are always people who, understandably, are concerned and have worries. So, it's really about how we make sure that we are doing this on the basis of improving outcomes and acting on the best available evidence, then we have that engagement with the public and then actually do what we know will work and work best, and has the best chance of working with a greater level of consistency and pace. Because that's part of the frustration for anyone running any part of the service—not me, in a sense, but chief executives and other leaders, but, from my point of view, with my responsibilities, how we deliver more consistent change and improvement and the pace of dealing with that as well. So, really significant challenges for us to take on, and many of those are reflected in Rebecca's portfolio as well.

[9] The final thing that I'd say about what I think part of our agenda has to be in this term, as well as the continuance of prudence, who has not left us, is the point about how we get the public to be more engaged in their healthcare choices; how we get them to take a different perspective on the choices they make as to the way they live their lives and the choices they make about that, as well as how they interact with health and care services.

[10] **Dai Lloyd:** Diolch yn fawr, Weinidog, am agor y drafodaeth. Roedd Lynne Neagle eisiau gofyn cwestiynau penodol nawr. Lynne.

Dai Lloyd: Thank you very much for opening the discussion. Lynne Neagle wanted to ask specific questions now. Lynne.

[11] **Lynne Neagle**: Thank you, Chair. I wanted to ask about the review of individual patient funding requests. The Cabinet Secretary will be aware that I've had very long-standing concerns about the current system. So, I'd be interested in having an update, but also specifically to ask how the work you are doing is looking at the area of exceptionality, which, in my experience, many clinicians particularly disagree with, and also generally how you are ensuring that there is good buy-in from clinicians to any changes that come forward.

[12] **Vaughan Gething**: Thank you for the question. As you'll know, we announced early on in this term that there would be a review of the IPFR process. We've had a range of very constructive discussions between the Government and political parties, and I have already made a statement on this in the Chamber. I also expect to be able to provide a fuller statement within the next few weeks, in the Chamber as well, on where we are, because I'm pleased to say that we've got agreement on outline terms, and I hope to be in a position, when I make that statement, to confirm membership. So, how that panel's going to be taken forward. It's still my ambition that the review itself will be taken within this calendar year, with recommendations for us to respond to, within this, if you like, financial year. So, we'll have a report, we'll then need to consider what that says. The report will be made available to Members—it won't be kept a secret—and we then have to make a choice about what we do. Exceptionality is one of the key parts of that review. You'll know this came partly from the agreement reached with Plaid Cymru, but, like I say, we have had sensible conversations with the other parties in the Chamber as well.

[13] So, I think you can take some reassurance from the fact that the review is going to take place. I'll be able to provide a fuller update in the Chamber, and I'm happy to answer questions then, or even afterwards in this committee again. We will have a membership that will ensure that the patient voice, in the way the review is undertaken, is properly taken account of, and exceptionality will be a key part of that. In whatever we decide in making these very difficult choices, the role of the clinician in having a conversation with their patient is really important. Part of the challenge that we have is some clinicians who don't agree with the criteria or it's about understanding the explanation. So, there's got to be some consideration through the review that there probably isn't—.

[14] We aren't going to be able to rehearse it enough now, I don't think, but the fact that that is going to be part of the review will be important,

because, whatever happens, if there is going to be a new criterion to be used—and I'm open to that—we'll be clear about the fact that, if there are alternatives to exceptionality that make sense and are better alternatives, then I certainly do not, and the Government does not, have a closed mind to that. There'd be no point having the review and talking about exceptionality otherwise. But, whatever happens, whether it's exceptionality or a different term or criterion that's used, we've got to be able to have a more sensible and consistent way of clinicians understanding their role and how that conversation takes place with the patient. For every Member in this room—and newer Members might not have had it yet, but you will do—there'll be people coming to us with concerns in this area, and in each of those instances, there are people who are genuinely concerned and worried, and there's a real sense that 'something should be happening, but it can't, and surely, you can unblock the log jam, and surely, you can make it work so that I can have this treatment that I'm told will help to improve either my life chances or my outcomes'. So, there's nothing easy about this, and the review should help us to get into a place where—again, a difficult choice—we'll have the best available evidence and advice on what we could and should do, but that won't take away from the fact that we're still likely to get difficult representations from individuals.

[15] There's something also about taking on board the all-Wales cohorts, because I'm also concerned—I know this will be part of the review about dealing with some of the potential inconsistency in where decisions are made as well. So, that is very much in my mind, and it will be part of what the review does, and I hope that you can take some confidence from what I've said previously, today, and also when I make a fuller statement to the Chamber outlining and, hopefully, finalising in public the names of the people who will take part in the review, the timescale for it and the terms it will work to as well.

[16] **Lynne Neagle**: Thank you for that answer, which is very encouraging. I mean, consistency is really important. One of the things I've called for previously was for there to be a national panel. I know that that's something that's been rejected previously by Welsh Government. Can you just confirm that that is something that is on the table to be looked at as part of this review?

[17] **Vaughan Gething**: We don't have a fixed position that says we want this review to tell us we'll definitely have a national panel, or that we definitely won't. We'll be asking the review to look at the issue of the panels

that we have and to tell us whether it is feasible and it's the right thing to do as well. That's what I'm interested in: how do we improve the system so that it works, and works at its most effective? Because, previously, the advice was that a national panel would slow down decision making, and it would not be in the patient interest to do that. Well, if there is now a different way to operate that can actually deliver the consistency that all of us would wish to see, then, again, that is something that the panel would be specifically charged to look at and to give us advice on.

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

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

[20] **Julie Morgan:** I wanted to ask you about the new treatment fund. I certainly agree that access to drugs has been one of the big issues as an Assembly Member, and, obviously, we often feel very impotent in helping people. So, I wonder, could you just briefly confirm exactly what the new treatment fund is?

[21] **Vaughan Gething:** So, again, I made a statement in the Chamber in July, before recess. We expect to provide £80 million over the term of this Government to fund these new treatments. The fund is there to ensure that, in the first 12 months of new treatments being available—and these are treatments where there's an evidence base and there's a recommendation that they should be made available—to make sure that that is made available more rapidly and more consistently across Wales. There's been a recognition that, with new treatments that are recommended, they're not always available as rapidly or as consistently across the country. So, this should improve equity and access to evidence-led treatment. So, it's different from the IPFR review, because that's talking about those where there isn't an evidence basis that would be more generally available, but there may be an individual case to be made for treatment outside those terms. It's based on our experience in the previous term of making available, for example, the medication on hepatitis C, and so, it's about understanding when that comes up—and there are often expensive new treatments available—how do we help health boards in the first year, as it's often more difficult to plan in. Then, after that, our expectation from previous working is that, thereafter, we expect them to be able to manage that within their resources. So, we've got a particular sum of money to deliver on access and to deliver on consistency for these new treatments that are coming forward, and, you know, it is not something that is tied to a particular condition. This is about new treatments;

it's not about looking at one particular area, because we've had that conversation through most of the last term for one particular basket of conditions. This is something that is available on every particular indication. It's really about whether the new medication is there and available and is evidenced.

[22] **Julie Morgan:** So, the new medications will all have been approved by NICE or the all-Wales group.

[23] **Vaughan Gething:** Yes.

[24] **Julie Morgan:** There have been some changes in NICE, the way it operates, recently. I think they can now not only say 'yes' or 'no', but they say 'maybe', and I wondered how that would affect the way that this fund would work.

[25] **Vaughan Gething:** This is difficult—

[26] **Julie Morgan:** Awkward, I know.

10:15

[27] **Vaughan Gething:** Well, it's difficult because there isn't clarity, and I don't think NICE fully understand what they're being asked to do yet, to be honest. The UK Government wants to have this 'promising' category, and those are things where they're looking at the evidence—they haven't reached a formal conclusion but they know it's likely to be approved thereafter. So, we're looking to understand, with NICE, what this really means for them. We don't want to have a position where we're either duplicating what we're doing in the new treatment fund and equally we don't want to get left behind in the sense that we simply haven't considered what's going to happen.

[28] But I expect that, with the architecture that we're designing here in Wales, we'll be able to match that. Also, what the Government in England are doing is having a 'promising' indication for cancer-related medication. I don't want to get drawn into having one group of conditions that are seen to be more important than others. I think that's the wrong thing to do.

[29] **Julie Morgan:** Is that because they've got the cancer treatment—what replaces the cancer treatment fund?

[30] **Vaughan Gething:** Yes, and they'll look at this new 'promising' indicator. NICE is going to be involved in reviewing those treatments, so it won't simply be going back to the old cancer drugs fund, which, as you know, has ended. But I don't want to get drawn into having simply a process that only affects cancer patients, and other people with life-limiting conditions are left in a different position. I don't think that's equitable and that isn't the way we want to operate here.

[31] **Julie Morgan:** No, I can imagine people would come to us about those issues. A last question; the new treatment fund, is it or has it been consulted with patients—the setting up of it? I know it's a manifesto commitment.

[32] **Vaughan Gething:** It's a manifesto commitment, so we had—. It comes from the significant engagement we've had throughout not just the last term, but previously, about how we'll make sure that evidence-led treatment is made available on a rapid and equitable basis across the country. There was a recognition that there was an issue here for us to address; that's why it was in the manifesto and that's why taking it forward is one of our early commitments. It was in our headline top six commitments to actually try and address this if we were re-elected. So again, we're getting on and doing what we said we'd do.

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

[34] **Dai Lloyd:** Okay. Angela.

[35] **Angela Burns:** I notice that it's called the 'new treatment fund'. Do you have any anticipation that, in the future, it might include technological advances, or is it simply medicines based? If it is simply medicines based, do you propose putting in some alternative form of being able to help with new technological advances that are coming on stream, because of course they are eye-wateringly expensive, but have the opportunity to change things enormously for people?

[36] **Vaughan Gething:** The focus of the new treatment fund is going to be on medication, but we recognise there's a need to ensure that broader treatments are available in a way that, again, is equitable. We're taking proper account of what new technology can deliver in terms of improving outcomes for patients. We've had a process about access to new technology, but part of this is about understanding the pace at which that new technology is made available, and the areas as well. We've often talked about

SBRT—stereotactic body radiation therapy. That got interesting when they came up with the term 'CyberKnife' so that people could understand about a different way and a more precise way to deliver a form of radiotherapy. So that was an example of a new treatment, a new technology, as opposed to medication. So we're aware—. And sometimes, new technology is much more simple. It can be about wound dressings. So different things are there and available. The treatment fund will focus on medication, but I'll ask Andrew Goodall to come in to explain some of our approach more broadly about new technology.

[37] **Dr Goodall:** And I'd hope that there are areas where actually we can be seen to be pioneering and leading in Wales. The Cabinet Secretary has mentioned about wound healing. One of our approaches to establishing the wound innovation centre, which is just over in Llantrisant, was actually a recognition that Wales has got some internationally leading research that attracts a lot of attention. We had an opportunity to ask ourselves the question, 'How do we engrain that more in the service across Wales as well as share the broader thinking?'

[38] We've continued with the technology fund that was established in the previous Government. That's been maintained. There's a £10 million sum of funding that's available, so that actually what we can do is get alongside not just very expensive products but actually some smaller-scale developments as well. We've also been using, Cabinet Secretary, links with the life sciences sector as well to see whether we're able to get alongside Welsh companies and organisations that are developing products here. We would have a general expectation, though, that clinicians in health boards are also supported. I think our whole approach to research in Wales becomes quite important in this arena as well.

[39] We re-launched Health and Care Research Wales last year. That was deliberately intended to actually raise our opportunities. I hope that a whole series of different funding streams will come through just from research moneys that are available not least in Wales but actually more broadly in the UK as well.

[40] **Angela Burns:** Do you rely upon the universities, et cetera, to go out and find—or do you actually have a group within your organisation that keep an eye on what—? There have been some amazing advances, and I saw the other day that they miniaturised a tiny camera that you can just swallow in a pill and all this. Do you have people who look out for those kinds of things

so you can evaluate them, or do you rely on the universities to do that task for you?

[41] **Dr Goodall:** It's a combination of both, actually. All of our health boards in Wales are university health boards or have a teaching responsibility, and I think there's much more that we can do to grow with that sector. But yes, every health board has its own research department. They have clinical directors who are leads in that area and they have funding that is allocated through Welsh Government and out through the organisations, actually, to spend in these different areas. But I do think the academic links are a strong part of where we take NHS Wales for the future.

[42] **Angela Burns:** Thank you.

[43] **Dai Lloyd:** Diolch yn fawr, Angela. Os nad oes dim cwestiynau eraill ar yr adran yma, fe wnawn ni symud ymlaen i gysidro materion yn ymwneud â'r gweithlu, sydd yn dod mewn tair gwahanol ran: gweithlu'r gwasanaeth iechyd yn y lle cyntaf, wedyn gweithlu megis meddygon teulu, ac wedyn, yn drydydd yn y rhan yma, y gweithlu gofal cymdeithasol, yn eu tro. Felly, fe wnawn ni gysidro yn y lle cyntaf unrhyw gwestiynau sydd gennych chi ar weithlu'r gwasanaeth iechyd yn ei hanfod, cyn symud ymlaen at feddygon teulu. Rhun.

Dai Lloyd: Thank you, Angela. If there aren't any more questions on this section, we'll move on to consider issues relating to the workforce. That will be in three parts. We'll have the health workforce in the first instance, then the GP workforce, and then, thirdly in this section, the social care workforce. So, we'll consider, firstly, any questions you have on the NHS workforce, in essence, before moving on to GPs. Rhun.

[44] **Rhun ap Iorwerth:** Bore da iawn i chi. Un o brif argymhellion yr adolygiad o fuddsoddiad mewn addysg broffesiynol iechyd yng Nghymru oedd sefydlu un corff ar gyfer cynllunio'r gweithlu ac ati. Mi gafodd yr Athro Robin Williams ei benodi i fynd â'r gwaith yn ei flaen. A allwch chi ddweud wrthym ni ble'r ydym ni arni efo'r gwaith yna erbyn

Rhun ap Iorwerth: A very good morning to you. One of the main recommendations of the review of investment in professional health training in Wales was to establish a single body for workforce planning and so on. Professor Robin Williams was appointed to take that work forward. Can you tell us where we are with that work?

hyn?

[45] **Vaughan Gething**: We've received Robin Williams's report, and it's being read through by myself and officials. I'm expecting some advice and I expect to be able to update Members within this calendar year on our expectation to respond. What was interesting is that the previous Evans review, and also tying into the review that David Jenkins led as well, in looking at the area of how we have a single body—I'm pleased there's a consensus about there being a single body, and it's really about how we try and implement that to make it a more consistent and joined-up approach. Different funding streams and different criteria are coming into this; it is a more unified approach to this area. So, I think you'll have—within this calendar year, there'll be advice that I've received, and I will then inform Members about the approach the Government is taking.

[46] I think this is a decision that we should be making and not putting off until the parliamentary review, because you'll know from our previous discussions that there are some things that we need the review to look at and others—and I think this is one of them—where we should not wait for the review, because that'll take probably at least another year before we get recommendations. I think we need to be able to set a direction of travel in terms of what we're going to do, because my concern is, otherwise, we'll lose too much time. We've had two reviews to try and help inform where we are. But, obviously, information from the Williams review and the advice we get will need to be fed into the review as well.

[47] **Rhun ap Iorwerth**: Can you identify now, in your mind, the areas where you are able to move ahead, where you're seeing the urgency as such that you cannot wait until the results of the parliamentary review, within the area of workforce planning, in particular—you know, the things that we can do now?

[48] **Vaughan Gething**: Well, this goes a bit into part of the debate we had yesterday. We are already going to be making progress on recruitment and retention for GPs. We are looking at the broader primary care workforce as well. So, in those areas, we're going to be launching a recruitment campaign this autumn. In the next month, we will launch part of our GP offer. We know we also will be doing work with the ministerial task group that I've brought together on the broader primary care workforce as well. So, some of those challenges can't wait, even though part of the context has to be there, in terms of what the review will do, but if we said we weren't going to do

anything other than 'steady as she goes' on this area, I don't think that would be acceptable. I think yourselves and colleagues in all parties would, quite rightly, be saying, 'You can't wait to do some of this, you have to get on.' So, that's a concrete example of what we will be doing.

[49] **Rhun ap Iorwerth:** You can set, in a way, perhaps, recruitment and retention, which is a response to an acute problem, with workforce planning, which suggests a more strategic approach to making sure that we have a sustainable workforce now and in the future. In order to do that, you need to have experts in workforce planning. Do you have the capacity within the NHS? How many workforce planners do you have in NHS Wales?

[50] **Dr Goodall:** I couldn't report the number of workforce planners, but, yes, we have very significant workforce departments. There's a director of workforce on every board of every health board and trust in Wales. Historically, I think sometimes it's been difficult to make sure that the commissioning numbers that we put in the system for the range of training posts, ranging from doctors right through to community-based staff are accurate. It probably has been difficult because I think the numbers have generated almost by rolling over individual years. I think the challenge that we introduced over the last three years with the integrated medium-term planning process and the three-year plan cycles was to try to make sure that we could be much clearer for the future. We've put a real emphasis around the services and the nature of them and defined them in order that we could start to track the workforce that we need, hence prompting a development around some of our numbers in different ways: I think an acknowledgement that, for example, we need to take more oversight responsibility around the care home sector and some of the nursing needs there, an emphasis around mental health, in particular, that maybe has lost out, traditionally, over the last number of years, and certainly a development around community staff needing to come into the system in a different way. I've seen development of that to a high level of detail over the last three years or so as we've introduced those plans, but I think it would be right to say, Minister, that we've still got some work to do to continue to improve that at this stage. As one example, we've already increased the number of nurses during this year, which was through your agreement, by an extra 10 per cent. In fact, they had gone up by 20 per cent last year as well. So, we have tried to take some genuine steps forward.

[51] **Rhun ap Iorwerth:** On that point, can I bring in the nursing bursary issue, if you could share your thoughts on that? Because, clearly, it is going

to be key to sustainable recruitment of nurses in the future.

[52] **Vaughan Gething**: As I've indicated both to Members that have asked me this previously and to the Royal College of Nursing as well, we need to take account of the review on student finance and support that is being carried out. Also, we need to understand where we are on the budget as well. I've indicated that there's no change through this calendar year, so nursing bursaries will still be available here in Wales. We'll then need to make a decision once we get through understanding what the Diamond review tells us and where we are from a budget point of view as well. It's difficult because I'd like to be in a position to set out now where we're going to be—the sooner the better. I do understand that but I'm not going to be in a position to do that, so I'm not going to try and do it on the hoof or just give a flier because I am going to give certainty when I can give it. So, we won't be able to do that properly until we get to the autumn—this autumn—and that's where we're going to be. But we're expecting to have this autumn both the student finance and the report from Sir Ian Diamond, and we're also expecting to have, obviously, the budget and publish a draft budget then. We can then do some more serious work on what we think the system could or should look like here in Wales.

[53] I recognise the broad point you make that nursing bursaries help a range of people with responsibilities in broader life. The average age of nurses going into training is 29, I understand, so it's often people with wider responsibilities. The support that they have to be able to enter the nursing profession is important, and there's also—we've got to think about, for example, the way in which healthcare support workers and a range of those who move into nursing to make sure that they can do it whilst they're still working, so they don't lose the ability to work and earn at the same time. So, those things are all in my mind as we think about how to take this forward to make sure that we can recruit and retain more nurses in Wales in the future.

[54] **Rhun ap Iorwerth**: And reflecting on the fact that they work, of course, during that training period.

[55] **Vaughan Gething**: Yes.

[56] **Rhun ap Iorwerth**: Another update that would be useful for the committee: the 'Shape of Training', a review, and the Welsh Government's response to that. Where are we at?

[57] **Vaughan Gething**: We're taking forward a work stream in Wales. It is relevant to some of the earlier areas you touched on as well.

[58] **Dr Goodall**: Obviously, it's a UK-wide review that was welcomed by all of the four countries at the time, in terms of the shape of training. I think we would be disappointed with some of the progress we made on a UK basis, and we need to continue to link with the other areas. I think it's important that we focus the agenda on what our needs are in Wales, however, as the Cabinet Secretary has said. The last meeting of the group, I think, took place in June. They'll be meeting again in November, and we're just trying to continue with our momentum. Certainly, we're aware in Wales that we obviously have many of the same pressures that are there. So, there is a need to look at some of the critical mass of doctors numbers and some of the issues around specialisms and specialties that perhaps are more short-staffed at this stage. But I think it's really important to make sure that we have a strategic approach here. There'll be some alignment with some of the other reviews, like the work that was recently being done around the HPEI review as well, but we'll be very happy to keep Members informed for the future.

[59] **Vaughan Gething**: Yes, of course.

[60] **Dr Goodall**: But certainly there's more disappointing progress, maybe, on a UK-wide basis at this stage, and we'll be looking to pick up the pace and momentum.

[61] **Dai Lloyd**: Y cwestiwn nesaf gan Angela Burns.

Dai Lloyd: Next question, Angela Burns.

10:30

[62] **Angela Burns**: Thank you. I just wanted to continue exploring this theme a little bit more. I'm very grateful for the response that you gave to yesterday's debate, and I totally understand that there is much effort being made to try to resolve the recruitment and retention issues with GPs.

[63] We talked about the wider workforce and I just wanted to highlight that again, because I think one of the concerns I have is that, in terms of workforce planning, are you getting a good oversight or are health boards—is it, you know, getting stuck at health board level? When you look at some of the enormous pressures that are going to happen over the next five years—

Hywel Dda, 30 per cent of practice nurses have indicated that they intend to leave within the next five years—those kinds of issues, are they filtering through to Government level so that you can look at this national workforce planning model? That would be my first question.

[64] I suppose the ancillary one would be looking at all the other professions that tie in, because I know, in previous committee reports that we've done, we know that there's an enormous shortage of speech and language therapists and educational psychologists, there's a huge shortage of eating disorder clinics, or the ability to access eating disorder clinics, because the people just aren't there; we're not training up enough of them. So, I think I just really want to have total reassurance that you get that whole picture and it's not being filtered through the various levels of the NHS.

[65] **Vaughan Gething:** I think there's a clear understanding of the range of challenges and the range of different areas of staff. It isn't just about GPs, it isn't just about hospital consultants, it isn't just about nurses: there's a whole range of different professionals who make up the service where there are particular challenges, either geographically or within some of those specialist areas. That's why, for example, when we look at the GP workforce, we set it in the context of the whole primary care workforce itself. So, we need to understand how we're going to have models of care running. So, the role of the pharmacist is important and the role of advanced nurse practitioners, and the work already under way, for example, with physiotherapists and occupational therapists too. It's about making sure—and this again goes back to prudence—who is the right person to give you the right care at the right time and how do we make sure that person is available? So, how do we make sure that GPs only do what only they can do, and physiotherapists do what only they can do as well?

[66] We've already seen, for example, in north Wales, that physiotherapy has made a really significant difference in reducing pressure on GP appointments, with the musculoskeletal assessments and work that they're able to do. Also, it's about avoiding people then going onto an orthopaedic waiting list as well on a range of things. This goes back to my earlier comments about the workforce we need having new and different models of care to be able to deliver a different sort of NHS to meet the needs that we have now and in the future.

[67] The pressures that we face aren't going to disappear, so, again, how do we plan that and then how do we deliver that on a consistent basis, I

think, is one of our bigger challenges, and you'll see that, once we launch the GP and the doctor recruitment programme, we will also then be working on a programme for other professionals as well, because we've already, in primary care clusters, seen significant recruitment of different professionals to come in and work with the GP workforce.

[68] What's been encouraging is that there's been some reflection on the role that other professionals can do, so it hasn't simply been that a bid for more GPs is the answer and the only answer, but it is about recognising that there are other professionals who can do things to make sure there is less pressure on GPs and more time for them to see the patients they need to. That's happened within clusters at a local level, and clinical pharmacists are a good example of where people are recognised and where they have a particular role that is helpful for GPs as well, but also in the way that the conversations have taken place with stakeholders—both the British Medical Association and the Royal College of General Practitioners—there's a clear recognition that they need different professionals to be part of the primary care workforce, and it goes into a whole range of different issues then as well, of course. So, what sort of primary care estate do we want? Well, actually, we understand what sort of model we want and what sort of workforce. So, that's why the newer developments that we've approved—whether it's in Blaenau Ffestiniog and Flint, and I've been to Hope Family Medical Centre, to name three in north Wales, where, actually, that's a better working environment for staff, there are different services that are available as well and it's actually better for the patient too. Actually, GPs who were previously a bit sceptical there now reckon that, actually, 'This is better for us. We have a better environment, a better model of working and our patients are in a better place'. There's some recognition that, whilst there are still GP workforce challenges, other professions are already making a real difference.

[69] So, there is that recognition, and you'll see that in the way that we deliver not just workforce planning, but our own objectives about training as well, and the money we've given and the uplift for a range of different professions to be trained, in the decision that the previous Minister made as well.

[70] **Angela Burns**: So, going forward do you actually see a place over the next, say, five years for there being more general practices owned and run by health boards rather than by private individuals, especially given some of the commentary recently that some of those that have gone into local health

board control have ended up being run better and more efficiently than they were before?

[71] **Vaughan Gething:** Well, this is part of the challenge about service reconfiguration in its broadest sense, because I would expect that, over these next five years, there will either be more federations of private care practices or there will be amalgamations. Some of that will come where people talk to each other, and sometimes that happens when practices can no longer run. The examples we're likely to get are the smaller practices or practices that can't recruit in, and sometimes that is linked to models of care, and sometimes that is linked to estate; there are a range of different challenges that are local. Health boards, it's a positive to say, have always been able to maintain an appropriate primary care service for the population, but there is always real concern and uncertainty, when a practice hands back its contract to the health board, about what will happen.

[72] But some of this is about how we work with the GP workforce and health boards to re-model primary care. I think this goes back to some of the maturity in the debate that I'd like us to be able to have, not just in this committee but more generally, because the easiest thing to say is it's the Government's fault or the health board's fault if a single-handed practice closes, rather than being able to say, 'Well, what do we do to make sure that primary care in this area can properly serve the local population, and what could and should that look like?' It goes back to this point about not just simply saying we'll invest in the same model of care, because that may not be sustainable. It's about how we have a conversation that is honest about what evidence we have about how we recruit people and what we can provide for a population with a different model of care.

[73] So, health boards need to be proactive in that conversation with their clusters and with individual practices. They need to understand the risks that currently exist within their local primary care workforce, and to have a proactive approach to trying to deliver that. Otherwise, we'll have a fairly predictable circle of practices under pressure, practices not being able to recruit, but if they hand back their notice it will almost always be, in someone's mind, the fault of the Government and/or the health board, and there'll be demands that I personally do something about it. That isn't me trying to avoid responsibility; it's actually about saying, 'Well, if we're going to resolve these challenges, there's got to be a different form of conversation about what is sustainable and what will deliver the high-quality primary care that we want to see in each part of Wales'.

[74] **Angela Burns**: But actually I want to turn it on its head more, slightly, and flip it round the other way, because I have seen instances where we have practices that are failing and there appears to be—not an unwillingness, but a legal inability for the health board to actually say, 'Look, you're not performing, you're not doing what you said', and because of the constraints—and this is stuff I don't really understand—about the contracts and all the rest of it, they can't put in extra GPs in a different building just down the road to pick up the slack because these other guys are failing. That gives me concern and I would like to know if there are any plans to review the contract, review the guidance, or wherever that decision sits so that health boards can step in and say to GPs—. Because, you know, not all general practices are great, and not all general practices perform the services they could perform. Some can't because they don't have the facilities, but others can't because they're just, to be frank, not prepared to do it. And it's not helping the population, so the population are incredibly disadvantaged. So, I'm interested to know what you can do to give the health boards a little bit more ammo so that they can go out there and say, 'You're not performing, so I am going to withdraw your contract', because it seems to be such a long-drawn-out process, and I'm not going to name them, but I have areas in my constituency where people have been terribly, terribly—

[75] **Vaughan Gething**: I could probably have an informed guess.

[76] **Angela Burns**: You could indeed. They've been terribly disadvantaged, and it's been going on for years. I'm not talking about the practices, I hasten to add, where they simply can't recruit but are actually good practices; I'm talking about the practices where they're not good and the population is suffering, and there seems to be nothing we can do about it. So, what ammunition do you have to change that?

[77] **Dr Goodall**: I do think that the GMS model—the contractual model—has served us well over the years on the NHS, but I think it's right to say that we need to be adaptable, with choices that GPs coming into the profession will want to make these days, and certainly in response to some of the pressures and challenges. Even with the number of GP practices that have had to be taken over by health boards, people always take quite a balanced approach about where they may look to locate it. Some of those practices have been maintained by health boards on a very good basis, going forward. Some of them, actually, may choose to be taken over by other individuals who want to come into an area and actually run it under the contractor

model, and others may look to merge it with their existing practices. But, we're certainly seeing an emphasis on larger practices coming together and sharing some of their resources in different ways, and there are some interesting models emerging in Wales, not least the federation approach that is being established in Bridgend, which we are just keeping an eye on.

[78] I think it's necessary to have quite an open discussion about the pressures and challenges that the GP profession and primary care are facing. I've been pleased, just over recent weeks, and this is through the Royal College of General Physicians, that they have actually facilitated some sessions in the evenings with senior colleagues from Welsh Government and officials, not least because we'll be able to give some proper advice, I think, to the Cabinet Secretary about the way forward on these areas. Actually, the contract is being raised there. I think, personally, that we'll end up, probably, with a bit of a mixed set of arrangements, going forward, but as time passes over the next 10, 15 or 20 years, it feels quite clear to me that people will start to make some different judgments about what they want. Certainly, some of our younger GPs are looking for different roles and greater flexibility. They're interested in working across pathways in a bit of a different way, at this stage.

[79] On the challenge of what health boards can do, on the one hand, we've tried to be realistic that maybe some elements of the contracts have perhaps become a bit over-bureaucratic at times, in terms of monitoring. What we don't want to do is to distort professional and GP time that's on the ground. But, there are mechanisms in place for health boards actually to challenge within the existing contracts. I think we need to reinforce some of those messages on a national basis as well. Certainly, I think what I'd like to avoid is a reaction to a set of local intentions when a practice has been struggling. So, over this last 12 months, for example, we have offered a scheme whereby GP practices are able actually to indicate that they are struggling, and it does give the health board an opportunity to get alongside them in a different way. But, I have to say, the take-up at this very early stage hasn't been quite as much as we thought, and we're just emphasising to health boards that we really want them to use that machinery. But, they are, in overall terms, responsible for the health of their population, and that includes making sure that the contracts work.

[80] **Angela Burns:** My final question, actually, is about patient choice. I understand and, I think, probably ultimately agree with the clustering model, but of course that can, in some ways, take patient choice, especially if the

clusters then actually become fully integrated and become these mega super-practices. What impact do you think that could have on patient choice and about the perception of patient choice by patients? What steps would you consider taking to try to, perhaps, mitigate that, or will you be looking at that? As we go forward over the next five years, I'm assuming we're going to probably get more and more of these as the smaller practices eventually retire and just get absorbed into some of these larger ones.

[81] **Vaughan Gething:** I wouldn't expect to see clusters becoming a single practice, but the clustering model is very deliberately aimed to promote joint working, so GPs understand what each other is doing. There's something about sharing challenges, and it's also about being able to get alongside other actors. So, social care, housing and others are part of arranging the clusters as well. So, it's actually about improving the service that those GPs provide, and they'll be able to agree with each other about the services to be provided across different practice areas, but to do that together in a sensible way. The money has been really helpful in delivering that as well. They've had control over some resource together to try to deliver that.

[82] I think the point about having larger groups running services goes back to the point about amalgamations and federations, which I don't think are likely to be seen. From my point of view, I'm interested in the quality of the service that people have, and whether they are getting the right services and access to services in a way that is appropriate for primary care. I'm not clear, to be honest, where you're coming from in terms of patient choice, because this varies according to where you are. If you live in the city of Cardiff, you've got access to a range of different GP practices within a radius of where you live. If you live in Solva, then, actually, the reality of choice is very different. So, my focus is on how we improve what primary care does, how we get the right model to make sure that we have the right services available and make sure that people are working in a much more collaborative way. That's why we've got a national primary care cluster event coming up in October—to bring together people to talk about what's worked and worked well, and equally to be able to identify what hasn't worked so well and why, because it's important to learn from both of those instances and to make sure not just that clusters learn within a cluster from each other, but from neighbouring ones as well.

10:45

[83] And there's got to be some space to be able to take a step back and

say, 'What are we doing and why, and is it delivering the sort of change that we think we need, given the populations we already serve within primary care, and how do we learn from people down the road who have a very similar population, to work within health need terms, and what can we learn from each other?'. And, sometimes, that doesn't happen unless you take the opportunity to do that. So, we're committed to making the cluster model work to improve the way that primary care works, in the context of our recognition that it will need to change, it will need to be different. And it will be different in different parts of Wales, as you would expect.

[84] **Angela Burns**: Thank you.

[85] **Dai Lloyd**: Lynne Neagle sydd nesaf. **Dai Lloyd**: Lynne Neagle is next.

[86] **Lynne Neagle**: I wanted to ask about the nurse staffing levels legislation, which I'm very enthusiastic about. But, one of the things I'm really keen on is seeing it extended to adult mental health wards at an appropriate time. When the Bill was going through, your predecessor said that he had commissioned some work on that. Can you just provide an update on that, and also confirm that that extension is something that you are looking to do at the earliest opportunity?

[87] **Vaughan Gething**: Yes. The Nurse Staffing Levels (Wales) Act 2016 is leading the way in the UK, and it's actually largely drawing on work that the chief nurse started before, as well. That work of the chief nurse in Wales is leading the way across the UK as well, in having a professional judgment of what is an appropriate level of nurse staffing. I've indicated, both publicly and in meetings with the Royal College of Nursing, that the commitment that the Government has made, that we want to see the extension of the Act, will be based on evidence. And, so, we'll have evidence from the Act being implemented, and, in terms of where it can then go next and what evidence we have about the right area, to say that we can now say, 'There is an appropriate provision to be made and this is an area where we can extend the Act'.

[88] So, what we're doing on implementing the Act, on the consultation we're having on the new model, will be really important for further areas of extension. I've been really deliberate in not giving a commitment to a timescale for further extension, but I've always been really clear that it is the intention to extend the Act based on the evidence that we have on where it is

the right thing to do. And you won't be surprised to hear that the Royal College of Nursing are keen to see the Act extended as well, but, equally, they understand the point about having evidence where it is, and they want to try and help us in terms of saying, 'Here's where we think the evidence is that this is the right place to say that you can now implement something similar.' So, at the earliest opportunity, and it depends on when the evidence is available that it's the right thing to do. It could be in whichever area—will it be adult mental health wards or will it be in children's services? We need to understand that evidence first, and for me to have that advice from the chief nurse about when is the right time and where is the right area. So, no definitive timescale, but a clear commitment to extending the Act when the evidence tells us it is the right time and place to do so.

[89] **Lynne Neagle**: Your predecessor did give assurances about adult mental health wards when the legislation was going through and said that he was undertaking work to gather that evidence. Is that work still ongoing for adult mental health?

[90] **Vaughan Gething**: Yes, the chief nurse is still leading that work.

[91] **Dr Goodall**: Yes, just to confirm, absolutely it's carrying on, and, in fact, it would reinforce the same methodology that we used around looking to increase the nurse staffing on the acute wards. What was really important was that we'd done all that background work—it will help the transition and also the implementation of these measures. But, yes, it's all in hand and in train.

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

[93] **Dai Lloyd**: Huw sydd nesaf. **Dai Lloyd**: Huw is next.

[94] **Huw Irranca-Davies**: Just to add to that, Chair, or to ask for some further clarification, we're very aware of the complexity of this, both internal factors within the NHS, within social care, but also external factors of recruitment as well. The Cabinet Secretary has been very, very clear on that, and it sometimes seems a little bit like whack-a-mole—you have to get everything whacked down to make this work, quite frankly. So, we get the complexity. I'm impressed by the strategic thinking and the rethinking that's going on to bring the workforce planning together. What I want to ask is on the issue of measurement and metrics, because of the old adage 'what you don't measure, you don't manage', and also accountability, and the role of

people like the schools within this—the school of nursing et cetera, and all the royal colleges. Do you feel that you've got the right metrics so that you can judge that everybody's delivering their part of it, that you can hold them accountable and responsible for delivering that in 12 months, in three years, in five years, and that, similarly, from the scrutiny perspective of this committee, we'll be able to look at you and say, 'Well, we can see not just the plans and the strategies, but we can actually see the outcomes—things fit. With the workforce planning now, we are fitting people into the right places, doing the jobs that we need, because we know how critical this workforce planning is to the whole of the transformation that the Cabinet Secretary wants to see.' So, on metrics, performance, accountability—those hard-edged things—are they there?

[95] **Vaughan Gething:** In terms of the extension of the implementation of the Nurse Staffing Levels (Wales) Act 2016, then, yes, we're in a place where we've got evidence of what to do, from the consultation, and about how that's done and giving health boards time to make sure that they can and then will do that. I was really clear, when implementing the Act, that it's not optional. It won't be, 'Try and do this if you want to', but it is, 'No, this is a requirement.' The same approach will be taken if and when we extend the Act.

[96] On the broader point about understanding what we measure and how we measure it. There's a conversation for the health service to have, and for all of us to have, about what to measure within the NHS anyway. Because, head count is one thing we can measure, but then that tells us only part of the story, and time and activity we can measure as well. So, lots of our measures and targets are about time and activity. They tell us something but not everything. So, there's something about the outcomes framework that we've introduced in health, but also building on the outcomes framework in social care as well, because I'm interested in getting us to shift to look at the outcomes that we deliver. So, there is the quality of care and the patient, but then there is the actual outcome itself and how we have achieved an outcome that is real and meaningful and how we measure that and are able to describe it in a way that has real purchase.

[97] I think that it's really important that we have that conversation and we're able to provide for you as a committee, but more broadly, that someone says, 'These are the outcomes that the health service is achieving and that social care is achieving'. I think that the nurse staffing levels is an area where you can say, 'You can tell us something about that, but it's got to

fit in within a wider whole, so that we're looking at the targets and measures that we have more broadly'. So, that is what I think we need to do within this term.

[98] We've already done it, for example, in the ambulance service, where we had an evidence-led approach to it and now the targets make sense and there is much more context actually for the care that is being delivered. So, we've got an improving organisation with a different range of measures to look at and different information for the public. So, you will now be able to scrutinise the service and the Government on a much wider range of issues and will be able to understand, from your constituents' point of view, the care that they're receiving from the ambulance trust. I think that's an approach that we could and should take more broadly across the service. But it will require some maturity in that conversation. To be fair, the Conservatives had something on this in their manifesto. I don't agree with lots of what was in their manifesto, but they had something about looking at targets again and having an evidence-led review involving clinicians.

[99] **Huw Irranca-Davies:** We know that targets can skew things as well, so they've got to be the right ones. But what I'm interested in is this issue of best practice within workforce planning. With the most complex organisation in the world—the NHS and social care and all the ancillary workforce issues around it—it may be something that at some point we return to, but it's about the ability of a Cabinet Secretary to turn to the whole of that and say in any one piece, but also in the whole, 'Are we delivering exactly those outcomes on workforce planning that we need to make this service work?'. Conversations—I think you're absolutely right in getting to that point, but it's just a hard-edged management thing of being able to say—as an old retired manager, I was told week by week, year by year or whatever—'Here's what you're accountable for, this is how you need to match it up and this is what you need to align for.' So, I don't underestimate the complexity. But I think, as to that issue of what we are looking for precisely, right across the royal colleges, right across GP recruitment, nursing and everything else, is everything bolted down, who's responsible and do we hold them accountable?

[100] **Vaughan Gething:** I don't really want to get on to 'everything is bolted down' because I think that's setting us up to a level of performance and undertaking that I don't think is honest. But there is clarity about the ambition and the expectation. Also, where does accountability lie within the system for me and chairs, and for the chief executive of NHS Wales and the

chief executives themselves as well? There is this point about health boards being much clearer about their responsibility and their accountability for whole-population health, and not simply about being hospital organisations first. That's partly what we need to see delivered more consistently over the course of this term as well. But there are important messages for us about outcomes from social care as well and the work that they've already done.

[101] **Dai Lloyd**: Mae hynny'n dod â ni ymlaen yn hyfryd iawn achos roeddem ni'n mynd i drafod materion yn ymwneud efo gofal cymdeithasol, a chyfle i'r Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol, Rebecca Evans, i serennu. Mae yna gwestiwn gan Lynne Neagle.

Dai Lloyd: That brings us very neatly on to the next issue because we were going to discuss issues related to social care, and so an opportunity for the Minister for Social Services and Public Health, Rebecca Evans, to shine now. There is a question first of all from Lynne Neagle.

[102] **Lynne Neagle**: Thanks, Chair. The Welsh Government launched a consultation back in January on how we can retain social care staff, particularly looking at domiciliary care staff. The consultation closed in April. Are you able to provide an update, and specifically comment on the fact that there was particular concern about how we can reduce the use of zero-hours contracts for the workforce in recognition of the fact that we were losing staff because of it?

[103] **The Minister for Social Services and Public Health (Rebecca Evans)**: Thank you, Lynne. Good morning, Chair, and good morning, committee. Developing, supporting and professionalising the social care workforce in Wales is one of my priorities within my portfolio. The background to the consultation to which you refer comes from a recognition of the real challenges that there are in this particular sector, such as the high turnover of staff, for example, and the perceived low status of what is incredibly important and valuable work as well. So, the background there was that we asked, via the Care Council for Wales, the Manchester Metropolitan University to undertake a piece of research to establish whether or not there was a demonstrable link between the quality of care that somebody receives and the terms and conditions of the person providing that care. The reason we did that was to better understand what we might be able to do in Wales under the terms of the Government of Wales Act 2006 and the powers that we have here, based on the understanding that we had after the Agricultural Sector (Wales) Act 2014 went to the Supreme Court and so on. I'm really

pleased that that piece of work did demonstrate that there was a clear link between quality of care and terms and conditions.

[104] So, the consultation then went on to look at, as you say, zero-hours contracts, but also other areas such as minimum wage compliance, health and safety at work, travel time and call clipping—so, issues that people in receipt of care had raised with Government, but also people who were delivering care as well. As you say, that consultation has been undertaken. I will be publishing a statement alongside a report on that in the very near future, in the coming weeks. And then that will outline the direction of travel as we move forward, including our approach to zero-hours contracts, because, of course, it was a commitment in our manifesto to tackle particularly the abuse of zero-hours contracts in the social care sector.

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

[106] **David Lloyd:** Julie.

[107] **Julie Morgan:** What about the cost of the sector—the increasing demands and the national living wage, and all of these issues? I know that they have written in to the Government. How are we going to cope with the increasing financial demands that importantly need to be there?

[108] **Rebecca Evans:** Well, we've continued to support and protect social care budgets in Wales. In the last financial year, we've provided an additional £21 million to local authorities in Wales in recognition of the fact that this sector is an expensive sector that puts a great strain on local government resources. We have also invested significantly through our intermediate care fund—£50 million. That's really transforming the way in which we deliver services, and the experience that people have of services. I'm happy to talk in more detail about that and give some examples as well. You did mention specifically the national living wage. I met with Care Forum Wales, and I know that there is a great deal of concern amongst providers in Wales that they will really struggle in order to be able to pay the national living wage to their members of staff. Of course, we have to remember that it's good news that we are paying low-paid workers more, but equally, at the same time, recognising the complications that that does give to the sector.

[109] The previous Minister established a group to look specifically at the national living wage—I think it has met on three occasions—to explore the kind of challenges it might pose, but also the kind of response that the

Government and the sector itself might be able to give to that. Would you like to add anything on this?

11:00

[110] **Mr Heaney:** Yes. Thank you, Minister, and thank you, Chair. I think in relation to the social work and social care profession, they provide invaluable, complex service support for people who have care and support needs in Wales. So, getting a strong, healthy workforce is absolutely crucial. Some of the challenges that we have to overcome have been mentioned by the Minister, but it is clear that, over a substantial period of time, whilst the Government has sought to support financially the social care sector, it's important to have a healthy, strong health and social care sector. Part of that relationship for us—. You'll be well aware of the legislation that has gone through the Senedd this year. The Regulation and Inspection of Social Care (Wales) Act 2016 has established Social Care Wales. I think it is worth mentioning today that there are distinctions between what Social Care Wales will do in relation to the workforce and what the Care Council for Wales did. The Care Council for Wales did some excellent work, but the additional transformational responsibilities, I would say, are in relation to improvement—working to improve the workforce—and in relation to, as was mentioned earlier, research—to better co-ordinate our efforts around social care research and research around integration so we can develop a stronger, professional workforce.

[111] We've got to establish in Wales more prestige. We see Social Care Wales helping us with that. As part of our relationship this year, the Minister has remitted Care Council for Wales, in its last year, before it changes in April of next year, to develop a five-year strategic plan to assist in relation to planning strategically for the domiciliary care sector. That plan will seek to support the delivery of the registration of the domiciliary care workforce in Wales, but also will assist us in taking forward, from the Minister's work, the consultation findings, and how we can develop a stronger, healthier domiciliary care workforce.

[112] My last comment is that it's important to see the scale of the workforce in Wales. We have over 70,000 in the social care workforce. So, it can be part of our well-being-of-future-generations thinking in terms of a prosperous Wales. Increasing the conditions and strengthening the conditions for our workforce can have a much added bonus in terms of both them and their local communities. And in the scale, we have over 14 million

domiciliary care hours commissioned by local authorities with the sector each year.

[113] **Julie Morgan**: It seems, as you say, absolutely crucial that the status and standing of the workforce is improved, for all the ambitions the Assembly has, basically. I just wondered, Minister, you did mention you had some outstanding examples that you could tell us. Was that from the intermediate fund?

[114] **Rebecca Evans**: That's right. The intermediate care fund, as I say, represents an investment of £50 million this year and we've committed to continuing our support for the intermediate care fund in our manifesto as well. This really is about changing the way in which we deliver services. It's about health and social care working side by side but also with housing and the third sector as well. I've spent some time over the course of the summer visiting schemes both in south Wales and in north Wales, looking at the difference that it's making in individual people's lives and in the lives of communities as well. There's a range of different models looking at different aspects of social care, from preventative and reablement services, single points of access, housing and telecare improvements, rapid response teams, dementia care and seven-day social care work as well. So, responding in different ways to the different kinds of needs of communities.

[115] People working in this area have told us that they see a difference in the way that they're working already in terms of much improved communication, quicker decision making, collaboration and a greater understanding of what partners can offer as well. So, health have now a greater understanding of what their social care, housing and third sector partners are able to offer.

[116] In terms of a specific example, there's an extended reablement for people with dementia scheme operating in Cwm Taf at the moment and they've been able to demonstrate already that over 103 hospital bed days have been saved, just in terms of preventing people from having to go into hospital in the first place or helping them return home with that reablement package in place as well. Obviously, through that we're offering telecare as well; 94 per cent of those people who were questioned as having received that service said that they were now remaining to live independently at home and 91 per cent said that they had achieved their own personal goals. So, I think that demonstrates, in terms of bed days saved, real success in terms of the NHS, but also people's own reflections on the way it's helped them to

stay at home and achieve their own personal goals. Really, what it's all about is the outcomes for the individual.

[117] **Julie Morgan:** How are we going to get that to operate all over Wales?

[118] **Rebecca Evans:** The intermediate care fund, as you say, is operating across Wales in different ways and there are mechanisms in place for information sharing, best practice sharing and so on across the different groups, so we can see what's really making a difference and what we'd like to roll out further as well.

[119] **Mr Heaney:** And just to add to what the Minister was saying in terms of the sharing, they had been all-Wales shared learning events. The regional partnership boards that have been established are taking a lead role in developing in accordance with their population need. And, in terms of a wider cross-Government approach, the Cabinet Secretary responsible for housing has also added to the £50 million fund available £10 million for capital this year.

[120] **Julie Morgan:** Thank you very much.

[121] **Dai Lloyd:** Roeddwn i ddim ond eisiau pwysleisio, cyn inni adael y materion i wneud â gofal cymdeithasol, ac yn benodol felly y gweithlu gofal cymdeithasol, o dan y ddeddfwriaeth newydd yr ydych newydd fod yn sôn amdani, a'r ffaith y bydd y gweithlu gofal cymdeithasol yn cael ei gofrestru am y tro cyntaf—wrth gwrs, mae meddygon a nyrsys wedi cael eu cofrestri ers canrifoedd bellach—. Hoffwn jest roi cyfle i chi bwysleisio unwaith eto fod hwn yn rhywbeth newydd i'r gweithlu gofal cymdeithasol a sut mae hyn wedi datblygu nawr dros y misoedd diwethaf.

Dai Lloyd: I just wanted to emphasise, before we leave issues related to social care, and specifically the social care workforce, that under the new legislation that you've just been mentioning, and the fact that the social care workforce are now to be registered for the very first time—of course, doctors and nurses have been registered for centuries now—. I just wanted to give you an opportunity to emphasise once more that this is a new initiative for the social care workforce and how this has been developing over the past few months.

[122] **Rebecca Evans:** I'll ask Albert to give the very latest developments over the last few months, but I would also add that we'll be including domiciliary

care workers in the registration as well, in 2020, and this very much is about increasing the status of the role as well. You know, it's being a registered role, and when you're registered then, it will give the people receiving care the confidence that you have a certain set of skills that will enable you to meet the needs of the person who is being cared for as well. Is there anything else to add?

[123] **Mr Heaney:** Just very briefly, Minister, in relation to the fact that social workers have been registered for a number of years, as you will be aware, but, in terms of taking forward domiciliary care workers, Social Care Wales will be working very much alongside Government officials and the Minister to deliver those changes successfully, both in preparing the workforce in terms of then moving into the registration, as the Minister has outlined today.

[124] **Dai Lloyd:** Grêt. Mae yna gwestiwn gyda Jayne.

Dai Lloyd: Great. Jayne has a question.

[125] **Jayne Bryant:** [*Inaudible.*]

[126] **Dai Lloyd:** Yes, that's the next slot.

[127] **Jayne Bryant:** Over the summer, I had the privilege of visiting the neonatal unit in the Royal Gwent Hospital and at Singleton Hospital. The staff there are doing an absolutely amazing job, in both hospitals. But you'll know that there is much uncertainty at the moment around the deanery consulting on neonatal training and I wonder if you can comment about this a little bit further, and also on what plans specifically are in place to attract neonatal nurses to work in Wales.

[128] **Vaughan Gething:** Okay, thank you for the question. This is an issue of obvious interest to Members not just in this committee, but, if you like, your sister, overlapping committee, the Children, Young People and Education Committee, as well as Members generally. The recommendation about having two training sites and a third site that runs a different model, if you like a hybrid model of not having training allocated, the Welsh Health Specialised Services Committee and the neonatal network are working this through, and my expectation is that they will have a recommendation for what will happen in the future of the network within this half of the term. There are always going to be challenges in delivering the right care, and delivering this really specialist care, to make sure that we prioritise outcomes for children, and whatever decision is made about which site is not going to have trainees in

the future, I would expect there'll be some local concern about that that will find its way to me in the form of questions or letters.

[129] But I just want to set out what I said yesterday, in that I won't look at this in the context of a local solution; it's got to be seen in the context of what is going to work—and were talking about south Wales now; there are three sites across south Wales, two of which are going to be training, and a third which will run this new and different model. It will have to be seeing about what makes the best sense for that whole population, and how to make sure that each of those decisions is linked to the others, to make sure that we continue to have a focus on improving outcomes, because the good news is that the most recent survey we've had about outcomes for children is that we compare well with the rest of the UK, and better than some other areas with comparable levels of deprivation. So, my focus is going to be on those outcomes, but I do appreciate that, within this, as with in a range of other areas, having had that indication that the deanery's recommendation has been for, of the three sites, one not to have training, there's going to be a level of uncertainty, and the sooner I get an indication of the services that will happen, and the sooner the service can confirm what it is going to do and talk to staff and the wider public about what that means, the better, because it's about trying to end some of that uncertainty and get back to focusing on having the right service model to deliver the best possible care.

[130] **Jayne Bryant:** Would you be able to give assurances that the quality of the service would still be there for people, with any changes?

[131] **Vaughan Gething:** We've been really clear and we need to be really clear that our expectation is the service meets the neonatal standards, the updated ones that tell us something about both staffing levels, but also, crucially, about outcomes. I think it's the perinatal health survey that gives us that confidence and that assurance about our outcomes being comparable with the rest of the UK and better than some other areas with similar levels of deprivation. So, that's what's really important for me. There is a challenge about having the right levels of staffing in each of those areas and we've got to recruit into each of those models of care, regardless of where they are geographically based. So, that's our expectation—that we will be able to do that. There's some evidence that we should be able to do that, based on the most recent evidence we've got. Also, at this point in time, they're undertaking a capacity review to understand where we are on staffing, and I think that we should have the results of that at some point in the autumn. I'd be happy to share the results of that with committee, if that's helpful, Chair,

to give some reassurance about the progress that we are making on staffing on this particular and really specialist service.

[132] **Jayne Bryant:** Thank you.

[133] **Dai Lloyd:** Ie, byddai hynny'n werthfawr iawn. Rhun nesaf ac wedyn Angela.

Dai Lloyd: Yes, that would be most valuable. Rhun next and then Angela.

[134] **Rhun ap Iorwerth:** Un cwestiwn penodol yn y fan yna o ran gosod safonau neu leiafswm safonau yn y maes yma yn gysylltiedig â lefelau o staffio hefyd. Un lleiafswm safon y gallech chi ei osod, wrth gwrs, fyddai pellter teithio i uned mamolaeth wedi cael ei harwain gan arbenigwr. A fyddai gennych chi ddiddordeb mynd ar ôl gosod y math yna o safon? Yn amlwg, yng nghefn fy meddwl i mae gwasanaethau mewn ardaloedd gwledig yng ngorllewin a gogledd-orllewin Cymru.

Rhun ap Iorwerth: There is one specific question there in terms of setting a standard or a minimum standard level in this area in relation to staffing levels too. Now, one minimum standard that you could put in place, of course, would be the distance of travel to a consultant-led maternity unit. Would you be interested in setting that kind of standard? Obviously, at the back of my mind are services in rural areas in west and north-west Wales.

[135] **Vaughan Gething:** There's actually been some work done on how much of a difference does distance to these specialist services make, and there isn't a great deal of evidence about how much of a difference to outcomes distance makes. But this goes back to the conversation we had yesterday in the Chamber and at the start of today as well about some of the challenges about what we do with really specialist services and how much of that is local and how much of that is going to be concentrated in a smaller number of centres to deliver better outcomes. I'm talking more generally. I know you're talking about consultant-led—

[136] **Rhun ap Iorwerth:** I wouldn't put consultant-led maternity services in the really specialist services category. Would you?

[137] **Vaughan Gething:** It is a specialist service. It's not the same as, for example, the neonatal service that we've just been talking about, but, again, we have to understand what our evidence tells us, and when we're talking about maternity services, you have to see them as a whole. So, for example,

we know that midwifery-led care, and there's lots of evidence and NICE guidance and recommendations about the number of midwife-led units we could and should have and about the safety of midwifery-led care. It should not be seen as bargain-basement level—that provides high-quality care. It's about having proper access to consultant-led care where it's appropriate. So, those people who are with higher risk pregnancies and if they are going to have consultant-led care, well, that should happen at an earlier stage. If there are people who need transfers at a later stage in pregnancy, it's about how we do that.

[138] There should be some confidence from the model in west Wales, because they've got a specific resource to take people from Withybush to Glangwili there, if there is a need to transfer women. The evidence has been that, in more than a year of that service being in operation, the care of women and their babies has not been compromised, and each transfer that has taken place has been done safely and there are good outcomes for mothers and their babies.

11:15

[139] The ongoing consultation about what could and should happen in north Wales is one where, again, there has to be evidence about what is the most appropriate form of care, how that gets staffed and how that is developed around the SuRNIC as well, which is a fixed point within the future of services within north Wales. There's good news on the SuRNIC. We've had the business case, and I expect to be able to receive advice and to make an announcement more broadly within this calendar year on that. Then, if there are future options about the future of consultant-led care, I'm interested in the service being able to discharge that properly, so that it's something that is clinically led and has an evidence base, there's a consultation with the public about what those options mean, and that the health board actually discharges that properly with their local population. I don't think it would be helpful for me to say that I am setting an entirely different criteria on a geographic route or otherwise, because that doesn't always take account of the realities of geography, and that doesn't always take account of what we are going to be able to do to deliver the right care for people when they need it. So, I understand why you raise the point, but I don't think it's appropriate for me to say there is a rule that I will implement and expect to see delivered on physical proximity to consultant-led maternity care. I'm interested in the quality of care that's provided or people's ability to access that when they need it.

[140] **Dai Lloyd:** Okay. Angela—your question.

[141] **Angela Burns:** My question is not entirely dissimilar, but concerns neonatal capacity. You talked about the fact that you're doing a review to look at the capacity of the nursing and other professional staff who are involved in neonatal care, which I've interpreted as for the beds that we currently have. So, my question to you is: do you intend to do a review of whether or not we actually have enough neonatal beds, wherever they may be, within Wales? Too many west Wales patients do end up further and further down the M4 corridor. My last constituent from Carmarthen had her baby in Rhyl. It was very premature, at 26 weeks, and is doing well, however, as you know, with a baby it is very difficult to repatriate them back. That baby was—they tried to find spaces in Swansea, then they went to Cardiff, then they went to Bristol, then they went to Swindon, and there were no spaces anywhere. So, I just wonder about the actual capacity. Do we have enough beds in south Wales and/or north Wales to be able to manage that situation? I think the point I want to make is I don't think it's a one-off, but I can only tell you the two or three instances in my patch, so I wondered if you might do a review to see how many babies are in premature care very far away from where they are, because it puts such an immense strain on the family and there's great difficulty in repatriating them. A baby born at 22, 23, 24 weeks actually usually has to stay there until it's pretty much full term, so that can be, sort of, two months or so that somebody's got to do those kinds of journeys.

[142] **Vaughan Gething:** I understand exactly why the question is asked and the impact it has on individuals. The capacity review where we'll look at our ability to meet neonatal standard is a regular review that we'll do to update people on what's being done and how close we're getting to meeting each of the different standards, and, of course, as we reshape services, we need to understand what capacity we need, and the reasons why there are times that that capacity will be shifted. There have been infection-control issues that have affected Cardiff on a temporary basis, and that may well have affected your constituent. But I've met some of your constituents, and others from further west in Wales, in Carmarthen, describing their journey from Cardiff back to Swansea back to Carmarthen. They've all been interested in the quality of care they've received, and they've had nothing but praise for it. The unfortunate circumstances you've described when someone goes to north Wales is unusual. It is not, if you like, a regular and frequent occurrence. But it is that we want to try to plan that to make sure we have the

right capacity within our system, as well as understanding, if people do need to go elsewhere, the reasons for that, to make sure that we minimise the instances where people are going outside, if you like, their normal, expected area—whether it's to north Wales or further into England—where that is not for a clinical reason. So, that's what we need to do in designing and delivering our system. It might help if Andrew gives some detail on how this is being worked through.

[143] **Dr Goodall:** As the Cabinet Secretary has outlined, we require the network to undertake a capacity review every six months. It's right to say that that information therefore gives us a baseline to know that we are improving both staffing arrangements and also looking to increase establishments. They have improved, even over the last six to nine months or so, which shows that the funding is going into the services. But there is a shortage of specialist neonatal staff on a UK-wide basis, and we obviously have to compete in that arrangement. I think therefore that it's really important that we do have links across the border, not least with English organisations and some other local provision. We also need to make sure through the review that we look at some of the transport arrangements. So, as an example, we've had 24-hour access seven days a week up in north Wales to support the provision. Actually, south Wales has been able to manage on a 12-hours basis, and then just making exceptional arrangements as necessary overnight, not least with some of the arrangements, for example, air ambulances and the emergency medical retrieval service. There's a current recommendation that, maybe, south Wales will need to alter some of those areas and we're looking for that to be decided on by the network at this stage. But I think it's important that we do have an opportunity to know what the future needs are—certainly the phase 2 proposals from Cardiff in what they can fit into their own space. They are giving some flexibility for additional cots that can be introduced into that area. There is already £7 million that's gone into the phase 1 development, which is actually taking place on the University Hospital of Wales site. But I'm sure that the review will draw it out on an all-Wales basis, not just these regional issues as well.

[144] **Angela Burns:** Thank you.

[145] **Dai Lloyd:** Lynne.

[146] **Lynne Neagle:** Just quickly, to go back to Jayne's point about the review of the training places, obviously the fear with a reduction in training

places on a particular site is that that then diminishes the configuration of the cots in a particular area. Are you able to offer any assurance that you will be taking steps to ensure that, whatever happens with the training, you will try to maintain the quality of service on those particular sites?

[147] **Vaughan Gething:** That's our expectation: that we will maintain the quality of provision. The last thing I would want to see is that we implement a model of care that diminishes the quality of provision and people's access to the right quality care at the right time. So, that's our ambition. There are challenges with any new model of care and with any changes that are made, but that's our clear expectation. That's what we expect the service to work to and deliver.

[148] **Dai Lloyd:** Andrew.

[149] **Dr Goodall:** If I could just say, it's really important that we make sure that that's not only for Aneurin Bevan health board to resolve. It's really important that the health boards all work together. I think there is a particular role for Cardiff to make sure that it's able to support some of the ongoing recruitment for what will be a new model of care for any of the sites. But there's a process that's being gone through at the moment, anyway, to determine which site would end up being of training-unit status or not.

[150] **Dai Lloyd:** Diolch yn fawr. Mae'n bryd symud ymlaen i'r adrannau nesaf o adroddiad Ysgrifennydd y Cabinet. Mae adran yn fan hyn ar dderbyn triniaethau gwrth-seicotig. Nid wyf yn gwybod a oes cwestiynau. Gallwch chi feddwl am hynny. Mae gan Caroline gwestiwn ar ddementia. Caroline.

Dai Lloyd: Thank you very much. It's time to move on to the next sections of the report of the Cabinet Secretary. We have a section here on the use of anti-psychotic medication. I don't know if there's a question on that. Whilst you're thinking about that, Caroline's got a question on dementia. Caroline.

[151] **Caroline Jones:** Diolch, Chair. Cabinet Secretary, people with dementia often require support for their families as well as themselves. How will you ensure staff are adequately trained to give this advice and also that nurses are fully equipped to deal with people suffering from dementia who need hospitalisation, perhaps for an unrelated illness? Thank you.

[152] **Vaughan Gething:** We've actually got some good news on where we are with our dementia strategy. I'll ask Dr Atherton to come in to explain

some of the work that's ongoing—that has taken place this week, actually. In drawing up our strategic action plan for dementia, we had the first meeting of stakeholders this week, and there are a range of the issues you mentioned that are part of what we are already looking to take action on and what we want the new action plan to take forward as well. I was able yesterday to set out, when I went to the University of South Wales, some of the steps already taken to make sure that there is further training and support for professional staff. We've invested not just in nurse training, but also occupational therapists and in different settings as well to provide support and meaningful activity. So, there are a range of different things that are happening, and some of that does include the support that is provided to and with families as well, because it's not just an individual themselves, it has an impact on a whole family, which we recognise as part of what we want to see happen and resolve. So, the third sector and dementia patients and their families and carers are very much part of helping us to design our new plan. There'll be a consultation this autumn, and we'll then hopefully announce what will be our final action plan later in the year. But I think Dr Atherton, it would certainly be helpful to talk about the meeting that took place at the start of this week.

[153] **Dr Atherton:** Thank you very much, Minister. Good morning, Chair, and good morning, committee. It's a pleasure to be here. I'm Frank Atherton, I'm the new chief medical officer. It's my first meeting with this committee, and I look forward to working with you in the future.

[154] As the Minister said, there was a meeting earlier this week of a very interesting group that came together to start to think about a dementia strategy for Wales, as part of our commitment to making Wales a dementia-friendly country. We had an excellent turnout. We had people from the voluntary sector, people from Government, of course, and from primary care. We didn't have a representative from the private sector, but we're looking to expand that. We had carers, as well, represented.

[155] So, we've started to make progress and, really, we started to think about how we develop a strategy over the next few months. We had an excellent presentation from the Alzheimer's Society, and some of the points that they were making were that we do need to think about those aspects that you mention around care, and how we provide care effectively for people suffering from dementia. We need to look at the whole pathway. We need to think about early diagnosis, so, what can we do to identify people early? Because there are interventions that can help if we find people and identify them early. How do we provide care and keep people in their homes as long

as possible? That's obviously a critical issue, but when people move beyond that ability to stay at home, what kind of care should we provide in a secondary care environment? And, also, we started to think about end-of-life care and how we can provide the same sort of services to people with dementia that we currently provide, for example, that we aspire to provide, for people with cancer? So, the whole pathway was under consideration.

[156] In terms of process, the first meeting was a brainstorming, was a getting together, thinking about the areas and the domains that we need to think of, in terms of both care and prevention. And from a public health perspective, I was delighted to hear people talking about that, because the evidence is building that those things that we do, that we think about in terms of keeping our hearts healthy, also keep our minds healthy. So, some of the work around smoking prevention, around exercise, that will be built in as well.

[157] We're looking to produce a draft strategy and to consult on that with the group, and then, more widely, with carers, with users, as we go forward into the early part of next year, and then to produce a strategy perhaps towards the middle of next year. That's the intention at the moment, but it's a very good group, great engagement, and a pleasure to engage with them.

[158] **Vaughan Gething:** Part of your question, Caroline, was on carers as well, so it might help if the Minister answered, as she's got responsibility for the carers strategy.

[159] **Rebecca Evans:** Yes, just to remind Members that, under the new Social Services and Well-being (Wales) Act 2014, carers now, for the first time, have the same rights as the people that they care for. So, they have the right to have a support plan, should they need one. So, I hope that that will transform the care that we give to carers as well. Now, carers have to identify themselves as carers; they don't have to provide evidence of providing substantial amounts of care either, so that should make it easier for carers to self-identify and to seek the support that they're entitled to.

[160] In terms of support for carers, we are refreshing our carers action plan at the moment, and the Alzheimer's Society will be consulted as part of that, because we're keen to ensure that we support carers who look after older people. And finally on that, I attended the British-Irish Council earlier this year, where a specific item of discussion was carers, and as a collective we identified that older people, and older people who care, should be a new

focus for action in the future as well.

[161] **Caroline Jones**: I'm pleased that there is support for carers, because I think the term 'carer' is so general and so vast really that we need to know that they are comfortable in dealing and helping people with dementia, as much as they are in any other field that they come across—people with physical ailments. So, that's comforting to know. Thank you.

[162] **Dai Lloyd**: Diolch yn fawr. Rwy'n ymwybodol iawn o'r amser sydd yn ymdreiglo ymlaen, felly buaswn yn gofyn am gwestiynau cryno, ac hefyd atebion cryno, am yr hanner awr nesaf. Felly, dechrau gyda Lynne.

Dai Lloyd: Thank you very much. I'm very aware of the time that is passing, so I would ask you to ask brief questions, and also to answer briefly, in the next half hour. So, we begin with Lynne.

[163] **Lynne Neagle**: Thanks, Chair. When I had the short debate on the national dementia strategy, I called for everybody with dementia to be given a support worker. The proposal that the Welsh Government published in 'Together for Mental Health' suggested one support worker per two GP clusters, which the Alzheimer's Society have estimated will be about 32 for the whole of Wales, which clearly isn't going to be enough. Can you confirm that that is something that you are looking at again to try and get more coverage for these new support workers?

[164] **Vaughan Gething**: It will be something that we consider as we develop the strategy, and that's part of the point about the consultation, about understanding what the needs are, and how we best support people living with dementia. So, it will certainly be something that will get considered as we develop the action plan, and you'll see there will then be a formal consultation on it as well.

[165] **Dai Lloyd**: Diolch yn fawr. Julie.

Dai Lloyd: Thank you very much. Julie.

[166] **Julie Morgan**: Two quick questions. I was very pleased to have the Alzheimer's Society train my staff a couple of weeks ago, and we were all very impressed and certainly learnt a lot. I wonder what opportunities there are to encourage training at every level of life really, because to make a dementia-friendly society, it needs to be everywhere, doesn't it? That was the first question. And the second one was that I was very pleased to visit

REACT—the community response enhanced assessment, crisis and treatment service—in St David's Hospital in Cardiff over the summer period, where they work with older patients with dementia, and take the hospital to the home almost, in order to keep people at home. I was tremendously impressed with the work that they were doing there, so I wondered what opportunity there was to extend that type of work.

11:30

[167] **Vaughan Gething:** You'll have heard from the chief medical officer that a part of what we want to do, and we recognise we should do, is about providing more care at home, and how we take services out of one particular setting and take them into a community or home setting as well. So, that's definitely part of our direction of travel. I think Rebecca will deal with the first point.

[168] **Rebecca Evans:** The training you would have had would have been part of the Dementia Friends scheme, which is something that I had the pleasure of launching as a backbencher two years ago. So, it's great to see now that we have more than 2,000 dementia friends across Wales—2,001 now. [*Laughter*.] It's a fantastic scheme in terms of changing the way that communities respond to and recognise the needs of people with dementia. I'm absolutely keen to continue supporting it and I'm keen to encourage other Members to take up that training opportunity as well.

[169] **Dai Lloyd:** Frank, did you want to wrap up on dementia before we move on?

[170] **Dr Atherton:** Just a couple of points on the last two questions. First of all, on the question of support workers, that was discussed at the meeting and we recognised that the number was relatively small. It was recognised also that support workers work in different ways—there are many different models emerging and we need to see what works best. There is also recognition that there are other people in the system who could perhaps take on that role, as well as dedicated support workers. So, there is definitely a capacity issue, but there are different ways of getting around that.

[171] Then on the point about information and getting information and education more generally, I'm sure that will be part of the strategy because making circumstances where people with dementia can go out into the community and not be subject to difficult circumstances, and how they can

interact in society, is a really important point going forward. So, that will certainly be in the strategy, I'm sure.

[172] **Dai Lloyd:** Diolch yn fawr. Symudwn ymlaen at yr adrannau nesaf o'r adroddiad llawn iawn gan Ysgrifennydd y Cabinet. Yr adran nesaf ydy ad-drefnu ysbytai. Mae gan Lynne gwestiwn.

Dai Lloyd: Thank you very much. We'll move on to the next section of the very full report from the Cabinet Secretary. The next section is hospital reconfiguration. Lynne has a question.

[173] **Lynne Neagle:** Minister, your report highlights the fact that you're still considering the full business case for the specialist and critical care centre for Cwmbran. As you know, the business case has been in with Welsh Government now since October last year, which is a long time. The development is hugely important, not just for communities in Gwent, but the whole of the plan for the south Wales programme is based on it. So, it is urgent now that we get a decision. When do you expect to make that decision?

[174] **Vaughan Gething:** Thank you. I do recognise that this has been an issue that you have consistently and persistently raised, to be fair to you, over more than one term, because I know this has taken a significant period of time. I'm grateful to you and some of the other Gwent AMs, who I've had the opportunity to meet with in this term as well.

[175] You're right to point out that this development is part of the south Wales plan, so it isn't just a Gwent issue. It's important for the delivery of services right across south Wales, so it's got to fit within that context. If I can be as helpful as I can, we've had an independent review through the summer of the business plan submitted. I've asked the chief executive to do some further review work, which will take us to a point where a decision can be made, because I recognise there's a point here about certainty and about being able to confirm that we can proceed with something that will fit in with the whole south Wales programme and the way we want to redesign healthcare delivery. So, I'm also keen to make clear that I think this has gone through three previous health Ministers and it's absolutely my ambition to be the last health Minister to have to make a decision on this, so that there is real certainty provided, and I recognise that it's the sooner the better. So, I can't share everything until I've got that advice, but that advice is in train and I expect to have it within this half of this term. As soon as that is available, I will of course update and inform Members.

[176] **Dai Lloyd:** Diolch yn fawr. Hapus? Reit, rŷm ni'n mynd i symud ymlaen at yr adran nesaf. Eto, ar dalu am ofal; nid wyf yn gweld cwestiwn. Beth am gynlluniau dyfodol gwasanaethau cymdeithasol? A yw pawb yn hapus gyda'r rheini? Ar faterion ariannol y gwasanaeth iechyd, a yw pawb yn hapus? Byddwn yn symud ymlaen i sôn am isafswm pris uned o alcohol. A oes unrhyw un eisiau sôn am hynny? Rwy wedi eich tawelu chi yn awr yn amlwg. Rhun.

Dai Lloyd: Thank you. Happy? Okay, we are going to move on now to the next section. Again, on paying for care; I don't believe there are any questions on that section. What about social services' future plans? Is everyone content with that? On NHS financial issues, is everyone content? We'll move, therefore, to minimum unit pricing for alcohol. Are there any questions on that? I've silenced you all now, clearly. Rhun.

[177] **Rhun ap Iorwerth:** Dim ond diweddariad ynglŷn â lle rydych yn tybio y gallem ni fynd yn y maes yma mewn cydweithrediad efo Llywodraeth y Deyrnas Unedig, am wn i.

Rhun ap Iorwerth: I'd just like an update on where you think we could go in this section in co-operation with UK Government, I assume.

[178] **Rebecca Evans:** Well, as I said in the debate on substance misuse earlier on this week, Welsh Government still believes that we are very keen to introduce minimum unit pricing, because we know the evidence is there that the price of alcohol matters and that introducing minimum unit pricing could be a high-impact proposal for improving public health and tackling the health harms associated with alcohol abuse in Wales. As you'll probably know, the matter's currently with the Scottish courts, and so, when we understand what the position is there in terms of legislation, we'll understand better what our opportunities would be to legislate on it in Wales. We are keen to do it. However, there's that as the first stumbling block. The second would be, of course, the Wales Bill, which might mean that powers are taken away from us in this regard, and we would be unable to achieve our ambitions on minimum unit pricing. We are lobbying the UK Government hard to ensure that we are able to do it. Any support that individual Members or, indeed, the committee would be able to offer on this issue would be much appreciated, because I know it enjoyed cross-party support in the previous Assembly.

[179] **Rhun ap Iorwerth:** And it's very pertinent, in that we have, as a

committee, considered the implications of, of course, the Bill and are concerned about it. Could you give us an idea of the kind of work that you're doing in order to try to ensure that the Wales Bill doesn't end up being a barrier to what could be the implementation of a very useful policy in terms of public health in Wales?

[180] **Rebecca Evans:** Well, it's a case of lobbying UK Government, but also taking other opportunities, because the House of Lords is currently looking at alcohol at the moment. So, we took that opportunity again, in terms of submitting our evidence, as making the case that this is what we would like to do. And the issues that you raised in the Chamber, also earlier this week, in terms of licensing as well, they were very much front and centre of our evidence presented to the House of Lords committee.

[181] **Dai Lloyd:** Huw.

[182] **Huw Irranca-Davies:** I'm assuming from what you're saying, Minister, that the intention would be that, when this comes to the House of Lords, you would like it resolved there, and it isn't far off.

[183] **Rebecca Evans:** Well, you make a good point in terms of timing being very important, because, if there was an opportunity for us to take action within our public health Bill in a timely way, in a way that would allow it to be passed before the Wales Bill, then that would be great, but it's very unlikely. So, it would be better for it to be resolved in the Wales Bill, and then we can get on with our ambitious plans for minimum unit pricing.

[184] **Dai Lloyd:** Diolch yn fawr. Symudwn ymlaen i'r adran nesaf. Bydd dilynwyr cyson y pwyllgor yma'n ymwybodol bod chwaraeon hefyd yn dod o dan ein cylch gorchwyl ni. A oes gennym ni gwestiwn ar y mater yna? Angela.

Dai Lloyd: Thank you very much. We'll move on, therefore, to the next section. Regular followers of this committee will be aware that sport is now also within our remit. Do we have any questions on that issue of sport? Angela.

[185] **Angela Burns:** I'd just like an update, actually, if possible, as to what the national physical activity director is undertaking in his or her remit. I'm not quite sure who the person is. We discussed in the debate yesterday about the levels of inactivity, and I thought Suzy Davies made some interesting comments about how we could soft sell some of this. Sometimes, if you come out and say, 'No, Government thinks you shouldn't eat the doughnuts'

or eggs, or whatever it is—you know, all fads—people tend to sort of think it's all that ebb and flow of contrary opinion. So, I wanted to understand a little bit more about the role of the physical activity director, and also understand a little bit more about the fact that, I know that the bumph that comes through my door is very much aimed at me and my kids, you know, our age bracket, but, of course, we are an older population in Wales and older people will have different ways of being able to access physical activity, and they will be very limited. They're not going to go out and run the five-mile run on Pendine sands tomorrow, necessarily—some might. I know I'm not, but some might. But I'd like to understand how we're going to actually get across the piece. And especially I do feel for older people, because they will often have things that are not working as well as they used to. They are often waiting for treatment. They've got bone issues, et cetera. And, of course, the more infirm you become, the more unable you are to move, the greater everything else starts going wrong. So, I do think it's really important that we make it more available in a very gentle and non-judgmental way, the ability to access different ways of keeping fit and just be a little bit broader. I just wanted to have an overview of what this individual intends to do. Will they look at the whole piece?

[186] **Rebecca Evans**: The national director is somebody called Jonathan Davies and he's been producing a report, which is called 'Getting Wales moving'. His role is a joint collaboration, funded by Welsh Government, Sport Wales and Public Health Wales. I think that's really important because it does reflect where we are now with bringing public health and sport and physical activity within the same portfolio. His report is—. Currently, we're asking stakeholders to look at the report. He's got many recommendations in it, so we're asking stakeholders: 'What is it within the report that you think will make the real difference? Where do you think our priorities should be?' Because Welsh Government have been so closely involved with it, being a tripartite collaboration, it did inform some of the work that we've already done and it will certainly be informing our healthy and active strategy, which we'll be publishing later on this year. So that's where you'll see, I suppose, the fruit of that piece of work in particular.

[187] With regard to older people, I met with the older person's commissioner and raised exactly this point—that I wanted to see how we could work closely together on what we could do to make sure that we build in physical activity—it doesn't have to be sport as such, but there are things like walking football and things that are becoming very popular now—and to see how we can work together on the physical activity agenda for older

people. She's already given me some good examples of things that we can look at that are happening elsewhere, but I'm really keen to establish what's already going on here in Wales and what we can do more on in this field as well.

[188] **Angela Burns**: Okay, thank you.

[189] **Dai Lloyd**: Rhun, nesaf. **Dai Lloyd**: Rhun, next.

[190] **Rhun ap Iorwerth**: Can I invite you to really share your vision, both of you perhaps, about how far you're willing to push this agenda? I'm very pleased that sport is included along with health. I think this is key to the long-term health of our nation. I'd like to know from you—I'm sure the committee would like to know—how innovative you are keen to try to be in order to push this agenda forward, working, for example, with other Government departments, with the education department, on increasing sporting hours at school, on physical testing at school in order to highlight potential health issues, on use of NHS funding for infrastructure investment in order to boost sport. Whatever it might be, how ambitious are you?

[191] **Vaughan Gething**: There's a clear ambition to have a healthier and more active nation. Activity is a big part of that. Some of that isn't about money, it's about what we can do together. The curriculum review in education will be important in terms of not just sport but physical activity, because lots of children and young people love sport, but there are others who don't. So, how do we make sure that everyone gets a message about the importance of activity?

[192] And there's an importance to working with Carl Sargeant as well, because an awful lot of this is about how you work with whole communities so the messaging that children and young people get is complemented and supported by the parent and carer communities, rather than getting very different messages on all sorts of public health messages and activity—diet, exercise, smoking and alcohol being the four big things that we know we could and should do something more with. That's why the First Minister decided to bring this department together. You're right about sport. It's the community and the participation end of sport that we have in this department. Ken Skates has, if you like, the major and professional end of sport as well. So, this is about how we get a healthier population.

[193] We are open-minded about what we could and should do and how we

want to work with other departments. What I don't think we should do is to try and set an ambition saying, 'We have ambitions to do three or four different things with other departments', as opposed to saying, 'See what comes up with our healthy and active strategy', and you'll then see something more about what we think we can do and will then do, working with other partners within Government and outside as well, because a lot of this is about changing the way the public think about their own health. It's what I mentioned earlier and about what you can do to be more active and make a real difference to your own health. It doesn't have to be going for a five-mile run on Pendine Sands, as you say; it can be a different form of physical activity that really does make a difference. For those of us who work in this building, and I work as an elected representative, we all know that lots of our life is very inactive until you get a big spurt of activity around election time. Even if you're campaigning throughout the rest of the year, this job is sedentary. So, we have examples to set ourselves in the choices we make as well. There'll be similar choices for the rest of the country.

[194] Part of our challenge is that lots of people understand healthy choices; it's about how we make them easier and not to be judgmental about them. Lots of people understand the message about five fruit and veg, but it's about how we make it easier and more accessible for people to want to do that and change some of the cultural norms, about whether that actually really does take place on a regular basis, and that's the same for activity as well. That's why, for example, Rebecca's leading the work for the Government on active travel. Because it isn't just about sport; it is that broader physical activity, and the norms of the way we live our lives as well.

11:45

[195] **Rebecca Evans:** I'd add, also, that there is a broader role for the NHS in Wales. We often, in committee—. I was expecting to come today and not actually have any questions on the public health agenda and the physical activity agenda, because it's often the case that, when we are talking about health, it's always in terms of response times, NHS configuration, GPs and so on. It very rarely actually comes down to the public health aspect, so it's really encouraging to have these kinds of questions today. I do think there's a wider role for the NHS, and we're meeting later on today with the chairs and chief execs of all the NHS organisations in Wales, and I will be making it clear to them that we do see a significant role for them in physical activity and that public health agenda there as well. So, we'll have those conversations today.

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

[197] **Huw Irranca-Davies:** I welcome that very much, and the point I wanted to make reinforces what Angela and Rhun have both said. I mentioned yesterday on the floor of the Senedd the Spirit of Llynfi community woodland. Yes, it's trees. Yes, it's development footpaths or whatever. But what is fascinating about it is that it's in one of the areas of most significant health disadvantage within Wales, not simply within my constituency. It's designed, with gateways into that area, for those light walks, as well as heavy-duty cycling up into the mountains, and so on, and it's working with GPs and with the schools, and so on. I'd prefer that we were talking, in some ways, in three, four or five years' time more about this and less about the repair costs, because this is the stuff that can do it. But I just wonder: we have gone a world now from in the 1980s, when I think the first ever GP referral scheme was there in Swindon at the Oasis leisure centre, and now we're into this sort of thinking.

[198] To pick up on Rhun's point, I think we do need to, as much as we can, push this right across departments in a very ambitious way, and connect not with expensive, high-duty, elite sport—important though that is in some ways—but more with how easy it is to walk out from your house, take exercise and socialise—the mental health benefits of socialising as well. So, please push hard on this, and I look forward to the strategy coming forward, but we'd love to see ambition, I think.

[199] **Dai Lloyd:** Lynne.

[200] **Lynne Neagle:** I recently joined a walking group in my constituency, for them to show me what they're doing. I was absolutely amazed at how many people went out walking, and also the really inspiring stories that they told. It wasn't just about exercise. Some of them had stopped being diabetic as a result of this walking that they were doing, but also it was a social thing. They'd made friends. Somebody had even met a new partner doing it. It was absolutely fab. Now, I understand that there's money coming from Welsh Government for that scheme. Is it your intention to continue with those kinds of initiatives? Obviously, with the budget pressures, that is a concern.

[201] **Vaughan Gething:** These take place through a range of different parts of Government. That's why I mentioned Carl Sargeant, particularly, because a lot of this takes place in Communities First areas, where they have support

groups to undertake this form of physical activity. Walking is very much part of what a range of clusters are doing in terms of trying to improve activity. That's why the healthy and active strategy will be a cross-Government strategy. It won't simply be about what we can do within this part of the Government. It is about looking across the Government, about who's got an influence, where it works and how we try and meet those ambitions to be a more healthy and active nation. I'm really pleased that you've taken the time to go and meet one of these groups as well. It can seem like a fringe activity. Sometimes people are very disparaging about ramblers. Actually, there's all sorts of ways to enjoy different parts of our country, and it really can be something that reinforces those points, and, again, there's the point that Huw made earlier about the mental health benefits of physical activity, seeing other people and getting out of the house, and the physical benefits that you see from it as well. So, I think that, within this committee, and from our side as well, there is acceptance of the benefits that can be gained. It is about how we do that and how we actually try to take advantage of that, because money is an issue. But lots of this can be done without spending huge sums of money. It's about a really significant cultural change that we need to deliver.

[202] **Dai Lloyd**: Julie, ac wedyn Huw. **Dai Lloyd**: Julie, and then Huw.

[203] **Julie Morgan**: Just to reinforce that it doesn't take a lot of money to make progress in this area, I had an event in my constituency about 12 months ago—an open event for older people, to find out what they wanted to do. One of the top things they had on their wish list was physical activity, and dance, in particular. So, now we have been able to establish Rubicon coming up to Whitchurch community centre and having a dance session for older people. They've loved it, and it's been tremendously successful. I understand, from Rubicon, that they also go into old people's homes and do a lot of movement with older people, which helps in so many ways. I was hoping that that is something that you would also be able to take on board—the dance element.

[204] **Rebecca Evans**: Absolutely, yes.

[205] **Dai Lloyd**: Dyna ni. Huw. **Dai Lloyd**: There we are. Huw.

[206] **Huw Irranca-Davies**: I wanted to ask something specifically on this issue to do with your portfolio: the idea of either GPs or nurse practitioners recommending light exercise, use of the outdoors, let alone leisure centre

stuff and all of that. How far advanced are we on that, because my perception is that it's a little sporadic? There are good clusters of GPs who have really bought into this. There are others where, frankly, it isn't happening. We do understand when they say, 'We don't have enough time to go through the mindset change to explain to people, 'We're not going to prescribe you medicinal products; we're going to prescribe you exercise and socialisation', but what's your assessment, as Ministers, about how far we are into this process where this is part of people's health and prescription?

[207] **Rebecca Evans**: Well, we've established Making Every Contact Count, which is how we're encouraging GPs and other professionals to have those kinds of conversations that you've just described with the people who come to them for help, assistance, advice and so on. You mentioned the national exercise referral scheme earlier on, and I've seen some of the stats. I was actually quite amazed, because we're talking about people who have been previously completely inactive. Seventy per cent of them, after completing the programme, are still exercising regularly. I think that's a real success story. But, as you say, perhaps something that intensive isn't for everyone, so we will be piloting social prescriptions over the course of this Assembly as well. Again, this is one of our manifesto commitments.

[208] **Vaughan Gething**: Just briefly on your point about consistency, Richard Lewis, the national lead for primary care, has taken a real and active interest in this. He's looking at ways to try and highlight what we're already doing, but also then to try and do something about the consistency and approach of that as well so that this is an active part of what we're considering within Government.

[209] **Dai Lloyd**: Diolch. Rhun. **Dai Lloyd**: Thank you. Rhun.

[210] **Rhun ap Iorwerth**: One from me again on the urgency. I see that you're supportive of increasing physical activity, and that's good, but again it's the urgency that I'm interested in. There's urgency, of course, because of the health of our young people and the future that they have to look forward to, but what about the financial side then, if that would help urgency perhaps? What comprehensive assessment has been made of the potential savings to the NHS from putting in place a real and successful campaign to increase the fitness of our young people through increased physical activity and sport?

[211] **Vaughan Gething**: All of us know that improving the general health of our population, dealing with those public health challenges, will have a

significant range of savings. In almost all of the delivery plans that we have for major conditions, I think there are major public health challenges that underpin the rise in demand for that. We could go and do an assessment if you like, but I think—

[212] **Rhun ap Iorwerth**: I would like.

[213] **Vaughan Gething**: What we understand is that, in each of those areas, there are significant savings to be made if we improve diet, exercise, reduce smoking and have more moderated levels of drinking. You could pick any condition, from heart disease to lung cancer, to dementia, to diabetes, and you would see the impact in each of those areas within that. What I don't want to do is to try and undertake an exercise that will appear artificial. We know that there are significant health gains to be made that will reduce the level of demand within the service. Andrew.

[214] **Dr Goodall**: Yes. I think it's important to mention, on the one hand, that we've put a lot of attention on the NHS as an illness service, but we need to reinforce its role around wellness in general terms. What might help this discussion—and we are currently reviewing what that means internally, and again to give advice to the Cabinet Secretary and Minister—is the economic case around prevention generally. There is an aspect of which, of course, where fitness and physical activity fits with that. Public Health Wales recently put into the public domain some information around their own evidence base that they've been able to gather. We obviously have an interest in that, from the Welsh Government. In fact, the Minister got alongside that to endorse it coming out into the public domain at this stage. So, we can draw in some of that information at the moment, but I think there's a role for the Welsh Government alongside just using Public Health Wales as an evidence base.

[215] **Rebecca Evans**: That evidence base is called Making a Difference. The committee might be interested in having a look at that. It has an executive summary report, which is quite accessible, and some infographics. But, then, it also does have quite a robust and significant piece of evidence work underpinning it as well, looking at the economic case for action in a variety of areas including substance misuse, for example, tackling violence against women, activity, mental health and other areas as well.

[216] **Dai Lloyd**: Diolch yn fawr. Wel, rydw i'n credu y dylwn i gloriannu'r sesiwn yna. Jest i'ch cynghori, efallai,

Dai Lloyd: Thank you very much. Well, I think we should just sum up that session. If I could just advise the

Ysgrifennydd y Cabinet, nid oes raid bod yn *sedentary*; mae'n bosib defnyddio'r grisiau yn y lle hwn trwy'r amser yn lle defnyddio'r lifft- 10,000 o gamau bob dydd sydd ei angen a gallai'r rhan fwyaf ohonom lwyddo i wneud hynny. Yn nhermau beth rŷch chi'n ei ddweud i werthu ffitrwydd fel tabled, mae yna ddigon o waith ymchwil i gefnogi beth rŷch chi'n ei ddweud, sydd yn enwedig wedi cael ei wneud yn Ysbyty Brenhinol Morgannwg yn Llantrisant. Mae'n darogan, o ddod yn ffit, fod pwysau gwaed pobl yn cwympo rhyw 30 y cant, mae lefel siwgr yn y gwaed hefyd yn cwympo rhyw 30 y cant, lefel y colesterol a phwysau i gyd yn cwympo rhyw 30 y cant. Petai hynny'n dabled newydd, buasai bawb yn gwthio NICE i'w gyfreithloni'n syth, ond mae'r ateb yna'n barod: jest dod yn heini. Felly, mae eisiau'i werthu yn yr un modd.

Cabinet Secretary, we don't have to be sedentary; we can use the stairs in this place rather than using the lift—you need 10,000 steps per day and most of us can manage that, I think. In terms of what you said about selling fitness as a tablet as it were, there's plenty of research to support what you've said, and it's been done particularly in the Royal Glamorgan Hospital in Llantrisant. It predicts that, if one does become fit, then blood pressure falls by some 30 per cent, blood sugar levels also fall by some 30 per cent, cholesterol levels and weight all fall by some 30 per cent. If that were a new tablet then everyone would be urging NICE to make it available immediately, but the solution is there already: it's just getting fit. So, we need to sell it in those terms.

[217] Rydym ni wedi rhedeg allan o amser nawr. Mae yna gwpl o gwestiynau bach eraill, ond, gyda'ch caniatâd, mi wnawn ni ysgrifennu atoch am atebion i'r rheini. Felly, diolch yn fawr iawn i chi am eich presenoldeb heddiw, Weinidog ac Ysgrifennydd y Cabinet, a hefyd Andrew Goodall, ac roeddwn i'n falch i gyfarfod â Dr Frank Atherton am y tro cyntaf, a hefyd Albert Heaney. Diolch yn fawr iawn i chi i gyd am eich presenoldeb.

We have run out of time now. There are a few other questions, but with your permission, we will write to you with those. So, I'd like to thank you very much for your attendance this morning, Minister and Cabinet Secretary, as well as Andrew Goodall. It was also good to meet Dr Frank Atherton for the first time, and Albert Heaney. So, thank you all very much for your attendance.

11:57

Papurau i'w Nodi
Papers to Note

[218] **Dai Lloyd:** Tra bod ein cyfeillion yn gadael, fe wnawn ni droi i eitem 6 yn fyr—papurau i'w nodi sydd yn fanna. Mae pethau un ai wedi'u hymdrin eisoes, neu er gwybodaeth yn unig. A oes gan rywun unrhyw sylw? Na.

Dai Lloyd: While our colleagues depart, we can turn to item 6 very briefly—papers to note. These are issues that we've either already dealt with or are there for information only. Does any Member have any comment on those papers? No.

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod ac o'r Cyfarfod ar 21 Medi 2016
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting and from the Meeting on 21 September 2016

Cynnig:

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

Motion:

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

Cynigiwyd y cynnig.
Motion moved.

[219] **Dai Lloyd:** Symudwn ni, felly, i eitem 7 a chynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod a hefyd o'r cyfarfod yr wythnos nesaf ar 21 Medi 2016. A oes yna unrhyw Aelod yn gwrthwynebu mynd yn sesiwn breifat? Nac oes. Diolch yn fawr.

Dai Lloyd: We move on, then, to item 7, which is a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting and from the meeting of next week on 21 September 2016. Does any Member object to our taking those issues in private? No. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

[220] **Dai Lloyd:** Fe wnaf i gyhoeddi bod y cyfarfod cyhoeddus, felly, ar ben. Diolch am bresenoldeb pawb, gan cynnwys y cyhoedd a hefyd diolch am y cyfieithu. Diolch yn fawr.

Dai Lloyd: I can now announce that the public session of our meeting is closed. Thank you for your attendance, including the public and thank you for the interpretation. Thank you.

Daeth y cyfarfod i ben am 11:57.
The meeting ended at 11:57.