Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Iau, 3 Hydref 2013
Thursday, 3 October 2013

Cynnwys
Contents

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

The proceedings are recorded in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
Christine Chapman	Llafur (yn dirprwyo ar ran Sandy Mewies) Labour (substitute for Sandy Mewies)
Mike Hedges	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Stephen Lisle	Arbenigwr Perfformiad, Swyddfa Archwilio Cymru Performance Specialist, Wales Audit Office
Dave Thomas	Cyfarwyddwr Iechyd a Gofal Cymdeithasol, Swyddfa Archwilio Cymru Director of Health and Social Care, Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru, Swyddfa Archwilio Cymru Auditor General for Wales, Wales Audit Office

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

Fay Buckle	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch Gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 13:15.
The meeting began at 13:15.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good afternoon, everybody, and welcome to today's meeting of the Public Accounts Committee. I remind Members and witnesses that the National Assembly for Wales is a bilingual institution and people should feel free to contribute through the medium of the Welsh language if they desire. Translation facilities are available through the headsets for those who require them. I encourage people to switch off their mobile phones, BlackBerrys and pagers, because these can interfere with the broadcasting and other equipment. In the event of a fire alarm, we should all follow the instructions of the ushers.

[2] We have had one apology for today's meeting from Sandy Mewies, and I am delighted to welcome Christine Chapman to today's meeting as her substitute. Welcome,

Christine.

13:16

Gofal heb ei Drefnu: Sesiwn Friffio gan Swyddfa Archwilio Cymru
Unscheduled Care: Briefing from the Wales Audit Office

[3] **Darren Millar:** This item is a briefing from the Wales Audit Office on its report on unscheduled care, which is an update on progress. I am very pleased to be able to welcome Stephen Lisle and Dave Thomas alongside the Auditor General for Wales to today's meeting. Auditor general, would you like to make a few opening remarks before we go into some questions?

[4] **Mr H. Thomas:** Thank you, Chair. As you said, the report, which we recently produced, tracked the progress of the development of unscheduled care services since we last reported on the topic in 2009. We summarised the local audit work undertaken at health boards and supplemented that with additional all-Wales research and analysis. We highlight in the report a system under significant pressure, with deteriorating performance since 2009 in key areas such as the handovers of patients from ambulance crews to hospital staff and waiting times at hospital emergency departments. It is clear that the rise in demand is one of the most important contributory factors to the pressure on the system. In particular, there seems to be an increase in the numbers of frail older people needing to access unscheduled care services. However, the problems are not just down to increased demand. There are workforce challenges, such as difficulties recruiting and retaining medical staff at emergency departments—and the Public Accounts Committee will have heard evidence on that before—together with problems in the GP out-of-hours services. Despite numerous initiatives seeking to ease the flow of patients through the hospital, blockages continue, ultimately putting further pressure on emergency departments.

[5] Deteriorating performance has prompted considerable additional focus on unscheduled care within NHS Wales. Since the spring of this year, there have been improvements in a number of the key performance measures for unscheduled care. This is positive, but I am cautious about the sustainability of these improvements, because we have found that some of the key underlying challenges that we identified in 2009 remain unresolved. More progress is needed in developing whole-system solutions with more community-based services in place to help to manage demand and to reduce reliance on the acute hospital sector.

[6] In 2009, we also found that the different types of unscheduled care services available could be confusing for patients, who might not know which service best matched their needs. This challenge still exists and further targeted public information and education therefore needs to be a part of the approach to manage demand.

[7] The report also highlights opportunities for improvement that NHS Wales must now grasp. There is no doubting the commitment of local and national leaders in trying to secure improvements. We say that they need to build on this commitment and come up with genuine, whole-system solutions. We highlight the planned introduction of the 111 telephone service as an opportunity, although we stress the importance of avoiding the mistakes made in England. We also identify scope for improvements in primary care to make it easier for people to access urgent care appointments. In many ways, primary care is at the core of the unscheduled care system. In-hours primary care services provide about 5.5 million urgent appointments each year and the out-of-hours services deal with more than 0.5 million calls. We see opportunities here, because small changes at this end can have considerable benefits for the rest of the system. The current proposals for the reconfiguration of hospital services

could potentially impact significantly on unscheduled care. While some plans are controversial, if the exercises are conducted intelligently, they present a rare opportunity to take important long-term decisions to secure the safety and sustainability of services.

[8] In terms of how the committee might want to take forward the issues raised in this report, there are a number of areas that the committee might want to explore further: whether there has been sufficient progress in optimising the roles that primary in-hours and out-of-hours care services play in the unscheduled care system; whether the 111 service will be delivered by the 2015 target date, together with details of how Wales plans to avoid the problems that befell the English model, and to what extend the 111 model will involve NHS Direct in Wales; whether the Welsh Government now believes that health boards have sufficient plans in place that will deliver sustainable improvements in unscheduled care; whether the inevitable increase in demand during the winter will be managed safely; whether the new national programme for unscheduled care is progressing well and delivering the positive impacts; and whether the continued high pressure on emergency departments is impacting on patient safety. The other two points that I would highlight are whether sufficient action is being taken to ease the longstanding problems of recruitment and retention in emergency departments and GP out-of-hours services, and to seek an update on the latest position regarding changes to ambulance services, and whether the changes are likely to produce sustainable improvements in performance.

[9] The committee should also be aware that, later this year, I intend to publish a related report on the management of chronic conditions, which will consider further the extent to which the shift to more community-based care is being achieved and reducing pressure on the acute services.

[10] Before I close, I will respond briefly to comments made in the press by the General Practitioners Committee (Wales) about one of the recommendations in my report. The chair and deputy chair of that committee appear to disagree with my findings about the scope to improve access to primary care. Their comments suggested that there is no spare capacity within general practice, and they are critical that the report does not highlight the increase in demand for GP appointments. In fact, the report rightly praised the hard work going on in primary care to deliver unscheduled care. However, in common with many other parts of the unscheduled care system, we concluded that there is scope to work better for the benefit of patients.

[11] Improving access to primary care remains a key Government priority—an indication of the need to look at this particular part of our healthcare system. The conclusions in the report about access to primary care are measured and based on evidence, including national surveys of patients, surveys of general practices, national data on opening hours, and interviews with clinicians and managers. So, while the report highlights a general increase in demand across the system, it does not provide detailed discussion of trends in demand for primary care appointments. That is largely because of the difficulties in obtaining this particular strand of the data, although the increases in the out-of-hours workload are referenced in the report. In conclusion, I believe that the report is balanced and measured on this matter, and the issue of primary care access might be one that the committee wishes to consider further in any future evidence session.

[12] **Darren Millar:** Thank you very much for those opening remarks, auditor general. You quite rightly pointed to a lot of issues that you have covered in the report, but which also require attention elsewhere. You indicated as well that the Welsh Government is already looking at some aspects of unscheduled care, and that the national programme board on unscheduled care is undertaking some work. Are you confident that the scope of the work that that board is doing, and the speed at which it is looking at these things, is appropriate?

[13] In terms of this committee, you made a number of references to primary care in your opening remarks. Do you think that that is a particular area that might need a little more attention and focus from this committee in any future work that we undertake?

[14] **Mr H. Thomas:** As regards the current national approach, there is greater priority now to improve unscheduled care. The new programme that the Government has announced appears to have more dedicated resource and a more comprehensive infrastructure below it in terms of groups and boards. Of course, it is early days. Simply introducing a new initiative does not guarantee success, and I think that we simply have to say that we need to monitor how well it progresses.

[15] **Mr D. Thomas:** I will say a little more about that. I think that Huw is right; I would not disagree there at all. There are some changes to the previous arrangements. You have clinical leads in place now, which were not there before. The Government has announced a national clinical lead for unscheduled care and one of the chairs of the health boards has been given that role as the lead chair. I think that will help. I think that the areas they are looking at are the right ones. There is a very good document called '10 High Impact Changes for Service Improvement and Delivery', which has been around for a while, and is referenced in the report, and I think that that has been reinvigorated a little bit in terms of the focus. So, I think all that is positive—really positive—but the proof of the pudding remains in the eating, and it is a complex set of challenges to tackle.

[16] **Darren Millar:** You mentioned, auditor general, your future work programme, and this piece of work that is coming through on chronic conditions, which obviously will have an impact, particularly with co-morbidity, et cetera, on unscheduled care. Are there any other pieces of work in the pipeline that you are undertaking as a Wales Audit Office around this particular subject?

[17] **Mr D. Thomas:** Not directly. That probably covers the totality of unscheduled care and what is happening in the community to reduce reliance on the acute sector. When you put those two reports together, you will see quite a clear picture of what is going on.

[18] **Darren Millar:** Okay; thank you for that. Mike Hedges is next.

[19] **Mike Hedges:** To quote from your report:

[20] 'delays remain frequent at various times during a patient's episode of care and patients are now more likely to experience long delays that are clearly detrimental to the quality and experience of care.'

[21] What evidence is available to support this statement, and did you experience any difficulty in gathering the data to support this statement?

[22] **Mr Lisle:** The comment is about the delays throughout the pathway. If you look at the way in which we have approached this report, it is very much a pathway approach, from the people accessing care, to the immediate response, and referrals onwards. If you look at that process from the initial assessment, accessing primary care, calling 999 if necessary, accident and emergency departments, and so on, you will see that all of the data suggest that there are delays, and people can face delays in those processes. There is a lot of information to support that. The data since 2009 suggest a deteriorating performance in much of those data. We are fairly confident in the data that we have on that.

[23] **Darren Millar:** There were some areas that had seen some improvements. You alluded to them earlier on. Can you just remind committee members which areas showed signs of improvement, and what their prospects are for further improvement in the future?

[24] **Mr Lisle:** The picture since 2009, which is the scope of the work, is one of deterioration generally, but since spring of this year, we have seen quite a marked improvement, which is to be expected, I guess, to some extent, because of demand levels at that time. But, it is quite dramatic—quite a marked improvement—and we suspect that some of that might be due to the reinvigorated focus on unscheduled care, which there definitely has been. On some of the other factors, if you look at access to primary care, although we are raising that as an issue, that has improved gradually—the metrics on that have improved over time. There are elements of improvement there as well.

[25] **Mike Hedges:** Did your investigation identify any specific parts of Wales where patients are facing problems and delays in accessing primary care, and, more specifically, specific doctors' practices? I can speak only of Swansea East, but I go to a doctor's surgery that I ring by 10.00 a.m. and as long as I am in the practice by 11.00 a.m., I will queue for probably half an hour to 45 minutes and I will get to see a general practitioner. I know of two surgeries in the area where I live that you have to ring by 8.00 a.m. to get an appointment that day, and if you fail to get one by 8.05 a.m., then you have to ring the next day. After two or three failures, I know a great number of people who just go to A&E because they know that it is the one place where they can get to see a doctor. That is anecdotal from me, from Morriston, but is it true of other areas?

[26] **Mr D. Thomas:** It probably paints an overall picture. We did not collect individual practice data for the audit. We did not have that level of detail, but we did get the overall trends and we spoke to people who would have given us a picture of the services. I can speak from personal experience as well. I am lucky enough to go to a practice that has got very good urgent care. I can phone up in the morning and speak to a doctor within 20 minutes, and if I need to be seen, I will be seen. But, I know that that is not the case everywhere, and I think that the example that you have talked about is quite interesting, because there is a huge variability across practices, in given areas and across Wales.

13:30

[27] The important point to make, I think, is that there is not a one-size-fits-all solution in primary care; you have to tailor it to the local population, local practices and what facilities you have in that area. I think that it is about having that flexibility and, more importantly, that people understand how to access the system and how it works. A lot of the time, people will default to A&E, not because they are frustrated that they cannot get an appointment—that is clearly one reason—but because they do not understand how access to the urgent care system works in primary care.

[28] **Mike Hedges:** I think that, in some places, it does not work in primary care, does it? I sometimes think that A&E is like a balloon—if you put pressure everywhere else, the only place that the air can escape is into the A&E part; that is one of the problems. Has anybody collected any data on people going to A&E by practice? You would expect a normal distribution, would you not? If there are any tails on that, perhaps that might identify a problem with one or more practices?

[29] **Darren Millar:** Is that A&E attendance per GP practice?

[30] **Mike Hedges:** Yes.

[31] **Darren Millar:** It is an interesting question, is it not?

[32] **Mr D. Thomas:** Stephen can come in here as well, but I am pretty sure that those data exist. If you did mine them—if you read into them—you could probably get them. When

you go to A&E, you should be asked where your practice is. Certainly, when you look at emergency referrals, they are able to break down referrals by GP practice. There is no reason why they could not break down A&E attendance by practice as well.

[33] **Darren Millar:** Do you want to come in on that, auditor general?

[34] **Mr H. Thomas:** I just wanted to comment that the point that Mike was making is absolutely right: where the balloon expands is in A&E. If you can track back—as emphasised in the report—right to the beginning, you may be able to prevent that pressure arising on A&E.

[35] **Darren Millar:** Escaping air—it is an interesting subject. Jenny, you wanted to come in on this; then, we will turn to Oscar.

[36] **Jenny Rathbone:** You quote the Welsh Government's statistics for 2012 on access to a GP; 65% of practices are not compliant with being open for the core hours between 8.30 a.m. and 6.30 p.m.. Why do you think that health boards have not done more work on this? There is a fairly obvious correlation between the failure by GP practices to operate during the hours that they are being paid to operate and people turning up in A&E.

[37] **Mr D. Thomas:** I think that that is a really good question to ask. I think that health boards are best placed to answer that question. What we see is that, in some health boards, perhaps you need a greater focus on the whole primary care world. They are integrated health boards; therefore, they have a unique role that the previous health boards did not. I think that it depends how well they engage their GPs. I think that that varies, so clinical engagement is a really important part.

[38] If you look at some parts of Wales—the Gwent patch is interesting—they have gone as far as putting an access rating on all of their practices. They have a number of As—up to five As—for different elements of access. That is a good way of starting to see where things like opening hours, half-day closures and appointments at the beginning and end of the day are put in place; it starts to build a picture of where you can and, more importantly, cannot access it. I think that you will quickly get into contractual discussions with GPs when you get into that area of extended hours. I think that that might be a slight impediment, because that obviously brings cost into the equation. In a cost-limited scenario, you tend to get very little progress.

[39] However, core hours are core hours, and I think that health boards need to be working with their GPs to understand what the capacity and demand issues are in primary care. Undoubtedly, there are pressures in primary care as much as there are inside A&E departments. It is about understanding those pressures, but looking to see where you can optimise and maybe rebalance some of that.

[40] **Jenny Rathbone:** How much of it is about cost as opposed to attitude? I note the remarks by the head of quality in primary care in England, warning GPs that they have to step up to the plate or he is going to close some of their practices. Is it not as much about attitude—not insisting robustly enough that people comply with the contractual obligations?

[41] **Mr D. Thomas:** I think that it is probably both, Jenny. I think that the contractual issue with GPs is interesting. Sometimes, that is a positive lever for change, and at other times it can be a lever that is difficult to get around.

[42] **Darren Millar:** Christine, I see that you want to come in on this point.

[43] **Christine Chapman:** I want to ask—I do not know the answer to this—about the

definition of being open, because a practice may be offering clinics, but not a GP surgery. Is there a definition of this that may be skewing the figures?

[44] **Mr Lisle:** It is a complicated one. I think that the contract says that the front doors need to be open between 8.00 a.m. and 6.30 p.m. without lunchtime closure, which I think is another complicating factor in the statistic that we just mentioned. A patient has to be able to come in and see a receptionist. That is the minimum. There are other complications within the contract that say 'Within those core hours, the practice has to meet reasonable patient need'. It is a cloudy picture.

[45] **Darren Millar:** What sanctions are available for health boards to impose on GPs if they are not meeting their contractual obligations? What can be done?

[46] **Mr H. Thomas:** Certainly, health boards should be aware of that. As Steven has indicated, there are core opening hours and you need to make sure that practices are open for that period. Going back to a previous question and answer, I think that there is scope for health boards to share data with GP practices—where does the practice stand in relation to others and what about the flow through, and whether they are seeing more through into unscheduled emergency care as a result. That requires a good set of interchanges between the health boards and the GP practices. The aim of the creation of the health boards was to bring primary and secondary care together, for that sharing purpose. Part of the need to follow through is whether the health boards have been able to concentrate as much on the primary as they have on the secondary hospital care.

[47] **Mohammad Asghar:** Thank you for your report. My concern with surgeries is that I get quite a lot of complaints from constituents about timing and the age factor. In your research, you have not noted that Wales has a much larger ageing group than other countries. The surgeries are making their own rules. There was a time when I could go to the surgery and get treatment, but not any longer. You have to make appointments, and there are certain times for that, and after that time they do not take the calls. Dentistry is worse. They have their own rule that if you miss two appointments they put you on private. The latest news this morning is that GPs are under financial constraints and are on the verge of bankruptcy; are you aware of that?

[48] **Darren Millar:** This is an issue of consistency in accessing GPs, and not just access to GPs but access to dentistry and whether that is putting pressure on the front door of A&E departments as well. What evidence was there on that front?

[49] **Mr D. Thomas:** I will be honest; we did not look at the dentist angle at all. We worked primarily on A&E departments alone, although I do not doubt the fact that if you have a dental problem and you cannot get easy access, you have exactly the same problem. There were two points in Oscar's question. The timing issue, which goes back to looking at access and opening hours—the times of the day for having appointments that are easier for patients to get to, at the beginning or the end of the day, as well as throughout the day. On age, if you have a practice with a demographic that is particularly old, which has associated chronic conditions, you will have greater demand. It is about understanding the information that is there to map the practice's capacity. Let us not forget that there will be constrained capacity. The point made earlier was about understanding what the typical profile of that demand is and matching resources to it.

[50] **Mr H. Thomas:** We refer in the report to primary care recommendations and 'Do you understand the demand from your patients?' That relates to demography, but it also relates to accessing appointments—can patients ring up at 08:00 and get an appointment in the course of the day or not. We compared two parts of Wales and I can certainly say that I share exactly the same patterns of delivery in the area of Wales that I live in. So, there are

differences. If all practices performed at the level of the best practices, I am sure that we would get more people through primary care.

[51] **Mohammad Asghar:** There was a time when doctors used to go to see patients after surgery hours, but that does not happen these days. I get complaints about that. The fact is, they spend their Friday afternoons, between 14:00 and 17:00, in their surgeries writing notes. I was told by a nurse, 'He won't be able to see you because he is writing notes; you better come back Monday'.

[52] **Darren Millar:** There is certainly a perception that it is more difficult to secure home visits et cetera. It is a fair point, Oscar.

[53] **Julie Morgan:** What other data do you think are needed? You have referred to incomplete data, so what do you feel is needed?

[54] **Mr Lisle:** There is quite a bit of commentary in here about the quality and depth of the data, particularly around demand. This report, as well as our previous report, talks about information being collected in terms of numbers going through services. That is fine to a certain extent, but we are saying that there needs to be better information about the needs of those people accessing the services, that is intelligent data around why people access certain care. Then you can use that to plan your capacity and your pattern of services better.

[55] In terms of data on outcomes, this is something that has always been talked about since we started this work—

[56] **Julie Morgan:** Sorry, what was that?

[57] **Mr Lisle:** Patient outcomes. There is not a lot out there. You have gone through a pathway, you have been looked after, but have you had a positive outcome from your unscheduled care episode? Data on that are still limited. We highlight some progress on that, but even the limited data there are on that have problems. That is quite a fundamental thing, we think.

[58] **Julie Morgan:** That would require quite a lot more research, would it not, to produce that sort of evidence?

[59] **Mr Lisle:** It would take quite a bit of research and quite a lot of agreement between all the partners in the system about what the outcomes to be measured should be.

[60] **Julie Morgan:** If you do not know the outcomes, you do not know what is effective, do you?

[61] **Mr Lisle:** No.

[62] **Mr D. Thomas:** That is what I was going to say. Outcomes are certainly a key bit that is missing. There has been a lot of work on putting data systems in place already. They have an emergency data set within the emergency department world, but when we looked at that, we saw that the completion rates of that data set were poor. Even where they have put a framework in place for collecting important information—simple information like what condition a patient presented with—the completion rates are quite poor. There is probably a very practical reason. If doctors are under pressure in A&E, the time to fill it in might be constrained. Nonetheless, it is hugely important information. If you are going to understand your demand, you really have to have that information available. So, you are right, certainly the outcome stuff needs a lot of thought. We are starting to see and hear positive moves that a lot of the NHS data will become more intelligent target based. While it is important to collect

your four-hour waits, as that is an important measure, the other important measures are the patient outcomes. As you say, if you do not know what the outcome of an episode of care was, how do you know whether the investment was successful in the first place?

[63] **Julie Morgan:** Do you think that the Minister has enough data to plan his forward work programme as things stand at the moment?

[64] **Mr D. Thomas:** I think that it is there. There needs to better compliance with what is there at the moment, but there are still key gaps. The ambulance review recently pointed to some important deficiencies in what we measure. It is correctly measuring the response to category-A calls. However, it does not say that, if you are a minute late for your category-A call, you might still get a really good outcome, but you have failed the target. Equally, if you are a minute early, it is a positive against the target, but who knows what the outcome was? The data need to be a bit more intelligent than perhaps they currently are.

[65] **Mike Hedges:** If I have been waiting three hours and 55 minutes with a broken ankle and somebody comes in who has just had a heart attack, I would think that the person who has just had a heart attack ought to be seen first. I would be happy go over the four hours. If you wait four hours before treating a heart attack, you are killing people, but for a broken ankle, four hours or six hours will not make any difference to the outcome. Do you not think that we need more intelligent targets based on why people are there? Otherwise, a hospital that wanted to perform well would leave the heart attack victim to wait while they got the person with a three hour and 55 minute wait in to be dealt with. It would tick a box, but it would probably kill somebody. Anything that produces such a perverse incentive to do wrong surely needs changing.

[66] **Mr D. Thomas:** It does. There needs to be intelligent targets and outcomes, absolutely. I would just urge caution about removing the four-hour target. I think that you do need some measures of transit through a department. However it is absolutely right that, if that is the be-all and end-all, then that is not right.

[67] **Mike Hedges:** For heart attacks, somebody should be seen within a quarter of an hour at the maximum.

[68] **Mr D. Thomas:** You have very tight professional guidelines on the administration of thrombolysis, for example. The clinical audits should be telling you whether you are doing that.

[69] **Mike Hedges:** However, those are better targets than having a four-hour target, no matter what.

[70] **Mr D. Thomas:** Agreed.

[71] **Mr H. Thomas:** We are going to be looking at waiting lists as another study, so this might help the area you want to look at in terms of unscheduled care.

13:45

[72] **Darren Millar:** However, it is interesting that you think that it is still important to have a four-hour target, from a managing patient flow and comparator point of view, to benchmark in some sort of way. That is the challenge, is it not? If we have a completely different suite of targets, while accepting that intelligent targets are a good way forward, you still have to be able to compare and contrast with other places that measure in different ways. That becomes more difficult if we all have different suites.

[73] **Julie Morgan:** Looking at the management of chronic conditions, did you find any evidence of consideration of chronic-conditions management in producing guidelines on unscheduled care?

[74] **Mr D. Thomas:** If you look at emergency admission rates for conditions such as diabetes, chronic obstructive pulmonary disease and others, you will see a positive trend. It is getting better. So, there is evidence that some of the programmes in place to help to manage chronic conditions are having an impact: they are reducing the emergency emissions, and that is a really positive issue. The report that we will produce on chronic conditions separately will go into more detail on that, and I do not have those facts in front of me today, but, in more general terms, for many years, the service has been talking about shifting care from the acute sector to the community. Certainly, there is progress there, but not the sort of pace of progress that you need to alleviate some of the pressures that you see in the acute sector at the moment. It is almost as if a step change in pace needs to come in now, because what you have is a lot of initiatives that are helping to improve the treatment of patients with chronic conditions but, collectively, they are not keeping pace with the demands that are being put on the service. The demands on the service are outstripping the initiatives that are being put in place, in terms of pace of change.

[75] **Mr Lisle:** The service is aware of the links between these two things, namely the unscheduled care system and chronic conditions. People with chronic conditions whose conditions exacerbate and then access unscheduled care is a well-known phenomenon. When we were publishing the report, the Welsh Government was interested in exactly what we were doing on chronic conditions as well, because it is aware of those things. It also relates to access to primary care, because a lot of its workload is chronic conditions management.

[76] **Julie Morgan:** You say that it is improving, but not keeping pace. So, what do you see happening in the future?

[77] **Mr D. Thomas:** You still need a fundamental look at where the resources are put. There has to be a shift from the secondary care to the community care sector, not just in terms of beds but staff too. You need to look at how you are supporting the workforce plans to say, 'Here is where we are now as a service shape, and here is where we want to get to in one, two and three years' time'. What are the workforce plans and the service delivery plans that are in place to support that? More generally, we are seeing some progress there, but probably a need for a bit more sophisticated planning to say, 'Here is how we get from A to B'. The pace of doing that needs to be upped a little bit.

[78] **Julie Morgan:** Seeing that the two areas of chronic and unscheduled care are so linked, do you think that there would be value in the committee doing a joint report on that after the report on chronic conditions comes out?

[79] **Mr D. Thomas:** I think that there would be. I suggest that you pause at the end of this session and reflect on the amount of issues that you want to explore just on the unscheduled care issue, because that could easily take up an evidence session by itself. There are absolutely clear links, and understanding what is going on in the community side of things, with issues such as chronic conditions, is clearly linked to how you manage unscheduled care. Locally, we have fed those issues back as a combined feedback. So, that shows that there is value in doing that. There are so many issues in both parts of those findings that there could be deep evidence sessions on them. However, you could do two separate sessions and link them together in a single report.

[80] **Darren Millar:** In terms of value for money, of course, you ought to get better bang for your buck in primary care, rather than through secondary care, hospital situations.

[81] **Mohammad Asghar:** My question is directly on the patient flow. Did your work identify why people are still accessing the incorrect services? What evidence do you have to support the suggestions that the system encourages people to access services inappropriately?

[82] **Mr D. Thomas:** Shall I start? There is a general concern that some people will still access A&E by default. We had a discussion earlier about some of the reasons why—because of the access, or perceived access to primary care. Huw addressed at the start and illustrated how complicated unscheduled care can be to people who do not understand how the system works. People understand what an A&E department is—it might be local to them—and if they do not quite understand how to access other parts of the system, they will go there.

[83] So, it is about public information and education. There has been some of that. There is the Choose Well campaign, which we refer to in the report. That had an initial positive reaction, but it did not seem to be embedded in making the change in behaviours that you need to get people to access systems. There is a little bit of a chicken-and-egg situation here, because, you can have all of the wonderful information that you want, but if those services are not in place for the patients to access as alternatives to A&E, they will go to A&E anyway. So, it is about having not just the information, but the services in place and properly mapped. So, it is about information, as to why people incorrectly access the system. I think that it is also about personal preference. The system clearly needs to understand where patients come from. So, if you go back to what we said earlier about the emergency department data set and understanding what patients' conditions are and how many of those could be treated outside of A&E, it is important to demand information to help you plan and address the problem going forward.

[84] **Mohammad Asghar:** You just mentioned public awareness, and, in Newport, the Royal Gwent Hospital is situated in an area where 32 languages are spoken. Basically, people enter from two entrances and there is one information desk, and half of the time, there is nobody there, especially in the evening. It has five or six floors, so people go there and go to totally different wards. That is a waste of time. There should be some sort of system when people come. I am not saying change to the 32 languages and put people who speak the 32 languages there, but there should be somebody to guide them when they enter the hospital.

[85] **Mr H. Thomas:** Given the difficulties that there have been in England with the 111 service, I am, perhaps, a bit hesitant to say this, but it does offer the opportunity to provide the signposting for people to prevent this default position, 'We will go to the local A&E'.

[86] **Darren Millar:** Yes. Mike, you have a follow-up question.

[87] **Mike Hedges:** It is only Morriston Hospital that I know, so I apologise for that, but, in Morriston, they have the out-of-hours GP, effectively, in the A&E department. Is that common? If it is not, would it not be a good idea to have them in the same place?

[88] **Mr D. Thomas:** I think that I am right in saying that it is not totally common. The answer to the second part of the question is 'yes, it is'. Most clinicians would say if you are going to get a footfall to A&E departments, perhaps the best way to filter off your demand is to have a co-facility.

[89] **Darren Millar:** Even in GP hours, it might be sensible to have a GP available within an A&E department, so that it is not automatically being dealt with as an accident or an emergency on an inappropriate basis. So, rather than an out-of-hours GP, an in-hours GP, within the normal day that the A&E is open.

[90] **Aled Roberts:** Rwy'n derbyn yr hyn rydych chi'n ei ddweud ynglŷn â defnydd

Aled Roberts: I accept what you say about the incorrect use of some services, but your

anghywir yn cael ei wneud o rai gwasanaethau, ond mae'ch adroddiad chi'n sôn hefyd am gynnydd yn y defnydd o'r gwasanaeth ambiwlans brys, galwadau i Alw Iechyd Cymru a gofal sylfaenol y tu allan i oriau. A oes rhesymau eraill, yn ogystal â'r ffaith nad yw pobl yn gwneud y defnydd gorau o'r gwasanaethau hyn?

report also mentions an increase in the use of emergency ambulance services, calls to NHS Direct Wales and primary care out-of-hours services. Are there any other reasons on top of, perhaps, people not making the best use of these services?

[91] **Mr H. Thomas:** Y peth cyntaf i'w ddweud yw ein bod yn gweld mwy o'r henoed yn mynd at wasanaethau brys oherwydd y problemau y maent yn eu cael gyda chael gafael ar eu meddygon teulu y tu allan i oriau. Mae hynny'n ffactor. Y ffactor arall yw'r hyn rydym newydd sôn amdano: y wybodaeth ynglŷn â ble i droi. Y meddylfryd, yn aml, yw eich bod yn mynd i'r gwasanaeth brys—ffonio 999 a chael yr ambiwlans a mynd i *A&E*.

Mr H. Thomas: The first thing to say is that we are seeing more elderly people using emergency services because of the problems that they have accessing their out-of-hours family GPs. That is a factor. The other factor is what we have just mentioned: the information about where to turn. Often, the mindset is that you turn to the emergency service—dial 999, get an ambulance and go to A&E.

[92] **Aled Roberts:** A ydych chi wedi edrych o gwbl ar drefniadau'r gwasanaeth ambiwlans? Yr wyf wedi dod ar draws rhai achosion yn y gogledd lle y mae diffyg o ran darpariaeth ambiwlans. Hefyd, mae'r gwasanaeth yn tanberfformio mewn rhai siroedd oherwydd y galw cynyddol ar eu gwasanaethau.

Aled Roberts: Have you looked at all at ambulance service arrangements? I have come across some cases in north Wales where there is a lack in terms of ambulance provision. Also, the service is underperforming in some counties because of the increasing demand on their services.

[93] **Mr Lisle:** We have looked at the ambulance service, but perhaps not in as much depth as our previous reviews of the ambulance service. In terms of some of the key points, its performance in terms of compliance with the eight-minute target, in percentage terms, has decreased, but, if you look at the number of people that it has responded to within that time frame, you will see that it has actually increased. So, that is a reflection of some of the demand pressures that it is under. In terms of how it deals with demand, it has internal targets for dealing with a certain proportion of patients at the scene and not conveying a certain proportion of patients. It is not performing as well as it should on those measures. Some of the key findings in this document are around the skill base of the paramedics and shifting it from a service that picks people up and preserves life there and then, and takes them to a place of safety. There is a recognised need to increase their skill base for assessment, decision making and perhaps avoidance of transporting patients elsewhere.

[94] **Aled Roberts:** What is your understanding of the current position regarding the review of the non-emergency responsibilities as far as the ambulance service is concerned? It seems to be patchy. I have six unitary authority areas in my region, and the provision is entirely different in each of the six areas.

[95] **Mr D. Thomas:** The understanding is that they will separate out the emergency transport from the non-emergency transport. I think that that was one of the key recommendations from the review that Professor McClelland did, and I think that we would endorse that. For a system that is under pressure, and having that additional sort of complexity with the variation that you mentioned, Aled, we do not yet know exactly where that is. I think that that might be the evidence that you will want to take from the Welsh Government, to see where it is with the recommendations for that review. However, as a principle of separating

those two bits of the service, that makes entire sense.

[96] **Jenny Rathbone:** To follow up on Aled's point about the causes of all this extra demand, all of the surveys tell you that elderly people want to die at home. Actually, most of them end up dying in hospital. So, how much of that is due to the fact that those people who are not dying are scared of the death process? In terms of referring people into hospital because they do not want to deal with the inevitable, how much of this is a cultural problem when we are just not prepared to have our loved ones at home or in the care home—the elder persons' care home—so, we refer people to hospital even when this is not really about a move for secondary or tertiary care?

[97] **Mr H. Thomas:** I am not sure about the right treatment in the period just before death, but, certainly, if we are seeing a growth in the elderly population, it is a question of saying whether the current configuration of the primary care system facilities, particularly for access to the out-of-hours service, is appropriate for a more elderly population, whereas we are assuming that perhaps we can have a model that fits a particular healthy, standard population. However, we need a different pattern to cope, particularly in parts of Wales where there is a large and growing number of elderly people.

[98] **Jenny Rathbone:** Moving on to focus on the impact of all this extra activity on the emergency departments themselves, it would seem to me that part of the problem is that we do not have—I could not find the reference, but somewhere in your report you talk about the lack of emergency nurse practitioners in accident and emergency departments who obviously can cope with some of the triaging that we were talking about with Mike Hedges, as well as the difficulty in getting consultants' vacancies filled in some of our hospitals. You have some very good bar charts on how there has been an improvement in most of our hospitals, although one is going backwards and two have stood still. That clearly has an impact on the quality of the care being provided in emergency hospitals. I wondered if you could say a bit more about the challenges ahead.

14:00

[99] **Mr D. Thomas:** In terms of the medical workforce, the challenges are UK-wide; they are not unique to Wales. I think that it is the attractiveness of working in emergency medicine compared with other professions in the medical department, and you have this vicious circle going on, really, where emergency medicine is seen as this under-pressure working environment, so are new doctors going to want to work in that environment? You have to crack both at the same time. It is not a Wales challenge, uniquely. I think that all parties—the Government, the deanery, the schools of medicine—need to work together to work out how you make accident and emergency more attractive. None of the departments met the College of Emergency Medicine guidelines for consultant shop-floor cover—although consultants would be on call—and I think that just exemplifies the challenge they have in getting that senior medical workforce there. Of course, if you have a consultant who sees patients, your outcomes are better and the decision-making process is quicker. So, it is vitally important that they do that. It is positive to see the increase in consultant numbers. We do point that out, but the middle grade is often where the key challenge comes in. You still see a real issue there, I think, in quite a few departments, and that means that the medical rota can be very thin in some parts of the day. That leads to a number of concerns, obviously.

[100] There was another part of your question which, I am sorry, I have forgotten.

[101] **Jenny Rathbone:** It was about emergency nurse practitioners.

[102] **Mr D. Thomas:** Yes. It is interesting, because I first looked at A&E services as an auditor back in the mid-1990s, and nurse practitioners were seen as one of the key issues to

move forward then. We still see now some difficulties in getting the numbers of nurse practitioners that you need. I think there are issues of training, and the availability of nurses with a willingness to take on that role, and an acceptance that that is a really important part of the overall workforce. It is very difficult to see why there has not been more progress because it seems to be a clearly logical thing to do.

[103] **Mr Lisle:** If I could just add to the point about emergency nurse practitioners, it is an issue of numbers, or getting them in, and of protecting them in that role. We have found that these nurses have been drawn into core roles, and then you are losing that expertise.

[104] **Jenny Rathbone:** However, in terms of managing the throughput in a busy A&E department, it is clearly important that people are seeing the appropriate personnel. As regards the pie chart you provide on page 44 about the proportion of emergency patients categorised as non-urgent, I have a huge question mark around that one because, as I recall, in my own health board area, in the discussions about whether we are configuring our hospitals correctly, 80% of attenders at A&E do not need to see an emergency doctor. An enormous number of these people are people who need some form of healthcare, but it is not the emergency, heart-attack type, or serious accidents that obviously require a consultant at A&E. Is it also inflated by the fact that the A&E departments themselves are perhaps not quite as ruthless in their categorisation? Why the disconnect between what I am told in my local health board and the national picture?

[105] **Mr D. Thomas:** Steve, do you want to take this? My initial reaction is that there might be different categorisations as to how they cut the data, so, in the overall numbers, you will see that the blue band looks quite small, but if you had indications by triage category, which is a bit different, you might see a slightly larger bit of the lower triage category. Is that right, Steve?

[106] **Mr Lisle:** Throughout the work, this was an issue that came up a lot—what proportion of demand should be elsewhere in the system, and the estimates are wildly varying, and the actual solid data on this are poor. There are limited academic studies, and limited local studies on it, but there is a lot of anecdote. It goes back to the issue of classifying people's needs; if you get better data on classifying people's actual clinical demand, then I think that is the key.

[107] **Darren Millar:** Christine, you wanted to come in, did you not?

[108] **Christine Chapman:** I just want to ask a few questions about the consultant posts. I wonder whether you have done any work, or whether you know of any studies being done, on women doctors? Obviously, over 50% of those now going to medical school are women, and that is good, but, at consultant level, there is a huge drop-off with women consultants because of the barriers that they face in departments, and because of, obviously, having children, and, until we clear those barriers, you will still be fishing from a very small pond of talent. Has any serious work been done on that?

[109] **Mr D. Thomas:** We do not have data on that, Christine, although I do not doubt that it is an important area to look at. I think that part of your medical workforce planning model is the need to look at what you need to do to attract people back to the profession if they have taken a career break. There probably are some studies—I do not know, but we can go away and make some enquiries if you like.

[110] **Mr H. Thomas:** What we do know is that, in terms of the number of women entering medical school, the majority will head towards general practice, rather than the hospital and consultancy areas. You can see the balance of life choices being made there. However, clearly, if we are to go forward, we need to maximise the use of people who graduate and are

qualified doctors in Wales.

[111] **Christine Chapman:** Also, those who have the talent to do it as well. It seems a waste, really, that so many people are dropping out when the country needs them.

[112] **Mr D. Thomas:** It goes back to the point you made earlier about all the key parties working together—the schools of medicine and health boards—to understand and optimise those issues to get those people back into the profession.

[113] **Darren Millar:** Aled, you wanted to come in briefly on this, after which I will come back to you, Jenny.

[114] **Aled Roberts:** In the discussions we had in north Wales during the reconfiguration proposals, it was quite telling that certain assumptions seemed to be made in workforce planning in Wales that were different in type to the practice in England. We heard evidence that—acute services have not yet been touched as far as Betsi is concerned, but in other disciplines—assumptions were made about rotas, and the rotas in Wales bore no resemblance to the rotas in England. Doctors were, clearly, going over the border because, you know, even if they chose to go into hospitals rather than general practice, they were asking themselves, 'Why would I choose to work in Betsi, where I could be on the rota once every seven days, when I could be at Salford Hope and be on the rota only once every 23 days?'

[115] **Darren Millar:** I should declare an interest: I was born at Salford's Hope Hospital.

[116] **Aled Roberts:** That explains a lot, actually, Chair. [*Laughter.*]

[117] **Darren Millar:** Do you want to respond to that point?

[118] **Mr D. Thomas:** No, other than to acknowledge that it is really interesting. It would initially need further exploration, because, clearly, a doctor faced with those two choices is going to go across the border. I am not familiar with that comparison, personally; I would have to look at it and see whether we are comparing like with like. It sounds as though we are, and that is a worry that poses a real challenge for that particular board in north Wales to have a set of rotas that is seen to be attractive to new doctors.

[119] **Aled Roberts:** I am unsure, as we have been developing the theme, whether assumptions are being made or whether the rota actually turns out to be one in 23 or whatever, just because they cannot get enough doctors. However, my feeling was that the workforce planning arrangements in England might be different from the Welsh ones.

[120] **Darren Millar:** There was a lot around the training rotas, was there not, in terms of recruitment? The health committee has been covering some of this, in fact, just this morning.

[121] I have to ask Members to be short and sharp with their questions, because the clock is against us, and, auditor general, if you and your team could be brief as well, that would be much appreciated. We now go back to Jenny and then we will move to Christine.

[122] **Jenny Rathbone:** Just briefly, is the announcement by the Minister for health last week, on the reconfiguration of A&E services in west Wales, likely to improve the recruitment of A&E consultants in those three hospitals where they have either fewer A&E consultants or have stood still? The other question is really around the role of GPs as part of the A&E team. You have mentioned Glan Clwyd as the only one that has a GP in its A&E team, but I recall that ABMU also has a referral pathway from GPs into the hospital for patients to be seen in a GP clinic to determine whether they really need to come into hospital.

[123] **Darren Millar:** This is about the clinical assessment units that run alongside the A&E departments, is it not?

[124] **Jenny Rathbone:** Yes.

[125] **Mr D. Thomas:** Shall I take the first part? Then Stephen can answer on the GPs.

[126] In terms of the reconfiguration plans in west Wales, I think that, yes, the ability to attract medics to properly populate all those departments is not there, and I think that all the research has clearly said that. So, what you need to do is to have a service configuration that is safe and sustainable, and which supports training requirements. So, the short answer is 'yes'.

[127] **Christine Chapman:** The report highlighted that there were continuing issues with efficient and effective discharges. It makes reference to positive examples of good practice, so is there any system for sharing good practice across health boards?

[128] **Mr Lisle:** In unscheduled care terms, the national structures that are being put in place would, you would hope, provide some of that. I do not think that we have seen, in the previous attempts, a really comprehensive attempt to share good practice, but we know that there are networks and that people are trying.

[129] **Mr D. Thomas:** The short answer is that Wales, collectively across most areas, needs to be better at that. It has the systems and structures to allow it to do that, but it does not make the most use of those systems to share. It could do more. There is a role for us as well in supporting that.

[130] **Christine Chapman:** It is not systemic, then.

[131] **Mr D. Thomas:** No.

[132] **Christine Chapman:** It is based on personalities and individuals.

[133] **Mr D. Thomas:** And perhaps programmes that are set up, which will drive it. However, as a collective, it needs to get better.

[134] **Darren Millar:** It is even inconsistent within health boards sometimes as well, is it not?

[135] **Mr D. Thomas:** Yes.

[136] **Darren Millar:** Okay. Thank you, Christine. Aled is next and then Oscar.

[137] **Aled Roberts:** Cawsom ddadl ddoe a oedd yn dangos rhwystredigaeth o ran yr Aelodau ynglŷn â diffyg integreiddio rhwng y gwasanaeth iechyd a gwasanaethau cymdeithasol. Roedd pobl yn sôn am gyfarfodydd yn mynd yn ôl rhyw 15 mlynedd lle mae pobl wedi bod yn addo bod pethau'n gwella ond nid oes llawer iawn o dystiolaeth o hynny ar lawr gwlad. Byddwn yn trafod y Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru) yr wythnos nesaf. A ydych yn teimlo, o ran rhai o'r problemau sy'n

Aled Roberts: We had a debate yesterday that demonstrated the frustration on the part of Members about the lack of integration between the NHS and social services. People were talking about meetings going back about 15 years where people have been promising that things were going to improve but there is not much evidence of that on the ground. We will be discussing the Social Services and Well-being (Wales) Bill next week. Do you feel, in terms of some of the problems that have been identified in this

ymddangos yn yr adroddiad hwn, bod cyfleoedd wedi cael eu colli o ran symud yr agenda yn bellach ymlaen?

report, that chances have been missed in terms of moving the agenda forward more?

[138] **Mr H. Thomas:** O ran y pwnc rydym yn trafod heddiw, nid wyf yn credu bod hynny yn gymaint o broblem, ond, o ran *chronic conditions* ac ati, mae'n hollbwysig i gael system integredig rhwng y gwasanaeth iechyd a gwasanaethau cymdeithasol. Credaf y bydd cyfle ichi edrych ar hynny pan ddawn at yr adroddiad maes o law.

Mr H. Thomas: In terms of the issue that we are talking about today, I do not think that that is the case, so much, but, when it comes to looking at things such as chronic conditions and so forth, it is all important to have an integrated system between the health service and social services. I think that there will be an opportunity to look at that when we come to the report in due course.

[139] **Mohammad Asghar:** Is there a further update on the reviews being undertaken by the health boards regarding the effectiveness of their enhanced services? That is one question. The second is: did the work undertaken by the audit office give an indication with regard to the effectiveness of these services and whether there is a need for more publicity and awareness-raising about these services to ensure that they are fully utilised?

[140] **Darren Millar:** This is where there has been extra commissioning, is it not, in terms of GP access with extended opening hours?

[141] **Mr Lisle:** There is not an update in terms of what we know from the reviews, but I know that they are quite complicated reviews. It is something like 30 or 40 of these enhanced services that are possible. As for some of the findings, I think that Abertawe Bro Morgannwg University Local Health Board was concerned that its enhanced service for access was not well used. I think it was looking at that. Again, this goes back to the issue of consistency, but also understanding your demand. That is, is there really a demand for that extended service? If so, then perhaps fund it; if not, perhaps do not fund it.

[142] **Darren Millar:** In terms of outcomes, they have not been fully evaluated yet, have they?

[143] **Mr Lisle:** I do not know where they are with it.

[144] **Darren Millar:** Perhaps that is an area that we might want to look at, in that case. Do you have anything else, Oscar?

[145] **Mohammad Asghar:** No, that is all right, Chair, thank you, as they are going to look into it again anyway.

[146] **Darren Millar:** Okay. Julie is next.

[147] **Julie Morgan:** My question was raised earlier on.

[148] **Darren Millar:** I would agree with that, just in terms of reconfiguration plans, et cetera.

[149] Are there any final points that you want to add, auditor general, before we bring this particular item to a conclusion?

[150] **Mr H. Thomas:** The only point that I would leave Members with is that we are talking about a wide range of areas that impact on emergency care. What we clearly do not want to see is continued high pressure on A&E departments, with all of the problems that that

creates in terms of backing up of ambulances and nursing in corridors, and so on. Therefore, when Members come to look at this area, it would be useful to look at some areas that you have not explored in the past.

02:15

[151] **Darren Millar:** Okay, thank you for that. Mike, did you want to come in very briefly?

[152] **Mike Hedges:** I have two very brief questions. On rotas, does the number of times that consultants are on a rota not depend on the number of consultants in the A&E department, which depends on the size of the A&E department, so that smaller ones will have people on the rota more often? The second thing is that we talked about A&E in the area of mid and west Wales. Is it not true that the major A&E department for people living in west Wales is at Morriston Hospital?

[153] **Darren Millar:** I think that patient flows is a matter for the health boards, is it not?

[154] **Mr H. Thomas:** It is certainly the case that the larger the A&E department, the easier you ought to find it to hold a rota in operation.

[155] **Darren Millar:** Okay, thank you for that.

[156] **Mohammad Asghar:** Chair, may I—?

[157] **Darren Millar:** Go on, Oscar, seeing as I let Mike in.

[158] **Mohammad Asghar:** I appreciate that unscheduled care has an effect on emergency services, and I am pleased that doctors, nurses and clinicians are doing their job, but the aftercare for patient treatment is not very good and not up to the standard in hospitals; I can assure you of that. Perhaps we can discuss that.

[159] **Darren Millar:** Okay. That is a point, rather than a question. We are very grateful for your briefing, which will certainly help to inform our discussion later about how we can take this issue forward.

14:16

Papurau i'w Nodi
Papers to Note

[160] **Darren Millar:** We have the minutes of our meeting on 24 September 2013 to note. I take it that they are noted by Members.

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

[161] **Darren Millar:** I move that

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

[162] There are no objections, so we will move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 14:16.
The public part of the meeting ended at 14:16.