



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

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

Dydd Iau, 18 Gorffennaf 2013
Thursday, 18 July 2013

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Cynnig o dan Reol Sefydlog Rhif 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order No. 17.42 to Resolve to Exclude the Public from the Meeting

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Leighton Andrews	Llafur Labour
Andrew R.T. Davies	Ceidwadwyr Cymreig (yn dirprwyo ar ran Darren Millar) Welsh Conservatives (substituting for Darren Millar)
Rebecca Evans	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Mark Drakeford	Aelod Cynulliad, Llafur (Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Health and Social Services)
Albert Heaney	Cyfarwyddwr, Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director, Social Services, Welsh Government
Dr Ruth Hussey	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
David Sissling	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol / Prif Weithredwr, GIG Cymru Director General, Health and Social Services / Chief Executive, NHS Wales
Martin Sollis	Cyfarwyddwr Cyllid, Llywodraeth Cymru Director of Finance, Welsh Government
Gwenda Thomas	Aelod Cynulliad, Llafur (Y Dirprwy Weinidog Gwasanaethau Cymdeithasol) Assembly Member, Labour (Deputy Minister for Social Services)

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

Mike Lewis	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerc
Victoria Paris	Y Gwasanaeth Ymchwil Research Service
Dr Eleanor Roy	Y Gwasanaeth Ymchwil Research Service

*Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.*

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning, and welcome to this morning's meeting of the Health and Social Care Committee. I welcome all Members, and I specifically welcome Leighton Andrews, who, since our last meeting, has been made a permanent member in place of Ken Skates. We have received apologies from Darren Millar this morning, but Andrew R.T. Davies will substitute in his absence. The meeting is bilingual and headphones can be used; channel 1 is for translation and channel 0 for amplification. Please switch off your mobiles and other devices, other than your iPads, as they may interfere with the broadcasting equipment. There is no scheduled fire alarm this morning, so if one occurs, please follow the ushers to the assembly point.

Craffu ar waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Gwasanaethau Cymdeithasol—Craffu Cyffredinol Scrutiny of the Minister for Health and Social Services and Deputy Minister for Social Services—General Scrutiny

[2] **David Rees:** I welcome the Minister for Health and Social Services and the Deputy Minister for Social Services to this scrutiny session. Thank you very much for the papers that you have provided to the committee. Could you introduce your officials, please?

[3] **The Minister for Health and Social Services (Mark Drakeford):** Thank you very much, Chair. I will ask the officials to introduce themselves.

[4] **Dr Hussey:** I am Dr Ruth Hussey, chief medical officer.

[5] **Mr Sissling:** I am David Sissling, director general of health and social services and chief executive of NHS Wales.

[6] **Mr Heaney:** I am Albert Heaney, director of social services.

[7] **David Rees:** Thank you very much. As you are aware, this morning's session is split into two sessions. The first session is for general scrutiny, and then we will have a short break before a second session on financial scrutiny. I invite Gwyn Price to ask the first question.

[8] **Gwyn R. Price:** Good morning, everybody; there is a lot of everybody this morning. On doctors, could you tell me what criteria are being used to assess the success of the medical recruitment campaign? What effect has the campaign had on the recruitment of doctors in Wales and on keeping doctors in Wales?

[9] **Mark Drakeford:** I will lead off on that, and will then ask the chief medical officer

to add some further detail. Just to be clear, the purpose of the medical recruitment campaign was to advertise Wales as a place where people would like to come and work and develop their careers. It has had a number of successes in that regard—in its presence at key events where medical recruitment happens in the United Kingdom, in advertising Wales as a place to work in the *British Medical Journal*, for example, and in developing a network of champions for the NHS in Wales who speak on behalf of the NHS at places where potential people who might add to the Welsh workforce are to be found.

[10] How do we monitor it? Partly, we monitor it through the ordinary processes of recording vacancies in the Welsh NHS. Over the last 12 months, that has been a generally improving picture. It is important to remember that 96% of all posts—medical and dental—in Wales are filled. The vacancy rate in the Welsh NHS fell from 3.2% in September of 2011 to 2.3% in March of this year. In the month that the medical recruitment campaign was launched, which was February of last year, there were 214 medical and dental vacancies in the Welsh NHS and, in March of this year, there were 174—a fall of 40. I am not claiming for a minute that there is a direct causal link between the campaign and that. However, during the period of the campaign, vacancies have fallen—they have fallen by a substantial number—and levels of vacancies for these posts in the Welsh NHS are at an all-time low. We are just at that point in the annual cycle where there will be training rotas to fill for 1 August. If it is helpful, I know that the chief medical officer has some of the most recent up-to-date information about recruitment as we go into this important part of the year.

[11] **Gwyn R. Price:** Following up on that, Lesley Griffiths was refused on numerous occasions when she tried to talk to the UK Government about immigration and how it affects us, with regard to the doctors from overseas who used to be able to come here. Have you had any more success with the UK Government than she had?

[12] **Mark Drakeford:** I think that there are two issues in relation to that. One is the policy issue, and, as you will have seen from the briefing, Lesley made a concerted effort to persuade UK Ministers to enter into a dialogue with us about how the way that they were changing the rules would have an impact on medical recruitment in Wales. By the time I became Minister for health, in a way, those decisions had been made. That was something that had been and gone and I have not attempted to reopen that because I did not feel that there was any prospect at all that those rules would be changed. There is a second-order issue to do with the administration of those rules. There was an issue last year particularly over visas within the new regime that was having an impact here in Wales. Officials dealt with that on an official-to-official basis and there has been some improvement in the interim period. The advice that I have on that front—the practical running of the rules that we did not approve of in the first place—is that, in a practical sense, we do not have the difficulties that we did.

[13] **Andrew R.T. Davies:** Minister, you touched on the figure of 96% and reel off how many positions have been filled, but I presume that they relate to positions that were advertised, rather than positions that were terminated. If you read various reports—by the Public Accounts Committee, which is just down the road—Betsi Cadwaladr health board, for example, was not advertising positions and was shutting positions. When you look at numbers of clinicians and medical positions that did not make it to the advertising stage and therefore were not filled, what do the figures look like on that basis? We are aware of the financial pressures and that certain positions have been closed down completely.

[14] **Mark Drakeford:** There has been a 45% increase in the medical and dental workforce in the Welsh NHS over the last 10 years. There are 300 more consultants in the Welsh NHS than there were 10 years ago. It is inevitable, right and proper that health boards should look at their workforce and decide where they want to make investments. Sometimes they will decide that a post does not need to be there anymore and will move that money to

invest in something else. So, there are more people working in the Welsh NHS year-on-year, and that is true of the last financial year as well, despite the huge pressures that exist. The figures that I have given you are for the overall complement, and the big-picture story undoubtedly is that there are more doctors, nurses and consultant-grade people than there ever have been before in the Welsh NHS, and we are very successful in most places. We always say—and I absolutely accept—that there is a small number of specialities to which it is continually difficult to recruit, but the big picture is that we have more people working and we recruit successfully to those posts.

[15] **Andrew R.T. Davies:** Minister, I make the point about the report of the Public Accounts Committee, down the road, which highlighted that positions had not been advertised. Are you in a position to let the committee know—maybe not today, but by written note—how many positions were terminated within the health boards because of reconfiguration and lack of resources, and from what particular disciplines those positions were lost? That is a very serious concern that many of the unions and professionals raise. With many jobs, when the person leaves, the position is not advertised and therefore lost to the NHS.

[16] **Mark Drakeford:** I am very happy to try to provide whatever we are able to in relation to that question, by all means.

[17] **David Rees:** Could you write to the committee with that information?

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

[19] **Lindsay Whittle:** I want to ask a question about doctors. With your permission, I would like to link that into the recruitment of nurses.

[20] **David Rees:** Rebecca was going to ask about nurses, but, yes, go on.

[21] **Lindsay Whittle:** It probably will not be the question that is to be asked later. Minister, we heard that Swansea has recruited extra doctors from Spain, I think, and that was very encouraging. Have the health boards considered advertising in countries that have an abundance of doctors—I am talking about Germany, Canada and Cuba. Cuba sends doctors to all sorts of other countries in the world, and I think that it would be good if we could go to those countries to recruit their doctors. They will come—the evidence is there from Spain. On the additional £10 million that you have allocated for nurses, did you instruct the health boards to consider specialist nurses? We have heard from so many charities in the last couple of years about the wonderful effects that specialist nurses can have on people who are suffering from long-term debilitating illnesses and preventing at least some of them from getting worse.

[22] **Mark Drakeford:** Thanks, Lindsay, for those questions. The obligation on health boards to look to European places to recruit people is greater, given the question we heard earlier about cutting off the supply of people coming from the Indian sub-continent. Abertawe Bro Morgannwg has had some success in recruiting from Spain. There is a particular project being worked up with Hywel Dda, which is looking to Ireland as well as to parts of continental Europe, partly because of physical proximity and so on and also because there is an over-supply of some doctors in Ireland, and so we think we may be able to recruit. You have to do it carefully, because medical training has to be comparable. You have to make sure that you are employing people who are able to do the job you want them to do. There are English language competence issues that are of a higher order than they once were. We have to be confident about that too. However, the basic answer to your question is that we are very keen for health boards to do that. The chair of the Welsh branch of the Royal College of Surgeons recently visited Cuba and provided a report to me—it is more generally available,

but he sent a copy to me particularly—in which he raises what he thinks are some promising contacts that would allow us to recruit from Cuba as well, and we will pursue those as a result of the contacts that he has made. So, the general answer is that we are very keen to pursue some of the lines that you have suggested.

[23] In relation to the nurses' money, no, it is not money for specialist nurses. It is money that comes as a result of the work that the chief nursing officer has been doing to develop a tool to allow us to identify the number of nurses we need on medical and surgical wards in the post-Francis era. That tool continues to be developed but is now at a stage where we think that we will have a better idea of the level of staffing we need, which is related, as you know, both to numbers of patients on the wards and to the acuity of their conditions. The money that I announced last week is to allow health boards to recruit in those contexts, rather than a general, 'Here's some extra money to employ extra nurses'. It is for that particular purpose.

[24] **Lindsay Whittle:** Thank you, Minister. Please do not rule out Canada and Germany, two of the healthiest nations in the world.

[25] **Mark Drakeford:** No, I do not.

[26] **David Rees:** We have two more supplementary questions on this topic, from Leighton and Rebecca, and then we have Kirsty.

[27] **Leighton Andrews:** Mark, you may not yet have seen the letter I have here from the Bro Taf local medical committee, but it goes to the heart of the relationship between GPs and the communities they serve. The letter relates to welfare benefits and appeals. It says that the LMC considers that it is not appropriate for GPs to be asked for letters of support. It goes on to say that that represents an abuse of NHS resources. Do you agree with that?

[28] **Mark Drakeford:** It is important, first of all, to be clear about what the LMC is. The LMC is a trade union branch. It is not part of Government. It is the way the BMA organises its membership. What the letter points to is part of the ongoing consequences of the welfare reform agenda being pursued by the UK Government with no thought at all for the way in which that agenda spills out into all sorts of other aspects of public services. It is undoubtedly true that we cannot dismiss the concerns of GPs, particularly GPs in areas where the welfare benefit cuts have bitten most sharply, that there is an unplanned, unfunded, large demand on GPs to provide extra information for the appeals process. It is a matter that needs to be resolved, and it needs to be resolved at a UK level, between the BMA and the Department of Health. They need to find a way of recognising the costs that are involved in all of this. Having said all of that, I am very disappointed to find a local branch act in this way, well beyond the discussions that are going on at a UK level about it. I would have thought that it is part of the ordinary duty of care that a GP owes to an individual who finds themselves in this very difficult position and whose health will be affected by it. Like you, and, I am sure, like other people around this table, I have people come into my surgeries who do not know where their next meal is coming from, nor do they know where they are going to sleep that night, when they are—as they very often are—embroiled in a dispute with the DWP, which involves an appeal and has a health component to it, and GPs are asked to play a part, then I think that they have a part to play.

9.45 a.m.

[29] **Leighton Andrews:** Thank you for the very helpful comments that you have made. The letter that I have here was actually brought in by a constituent of mine from a surgery in Ferndale, where it has been distributed. You know, as do I, that 41% of DLA cases and 43% of ESA cases are overturned in favour of the appellant on appeal, and, obviously, support from GPs, along with support from Assembly Members and MPs, is critical in the process. Is

there any way in which you can take this up with the BMA in Wales, to make it clear to it that this will have catastrophic consequences for the relationship between GPs and their patients, particularly in Valleys communities?

[30] **Mark Drakeford:** I have already discussed this with the chief medical officer this morning. I will ask her in just a moment to say what we will do in relation to the BMA, but I know that the Deputy Minister wants to say something, because this affects a huge number of social services users, just as much it does users of the NHS.

[31] **The Deputy Minister for Social Services (Gwenda Thomas):** Indeed. Lately, I have become aware that we need to ask who the onus for the production of evidence lies on. For example, I have a constituent who has appealed a decision, and, in making the appeal, she produced medical evidence. Subsequent to that, she was asked by the DWP to produce more evidence. She went back to the GP and was asked for £15 for the production of an additional letter or report. She had to settle, because she did not have enough money for a letter that would cost £15. In my view, we need to be clear—and I think that this would be helpful to both sides—that the onus for the production of evidence should lie with the DWP, in part, and also with the appellant or claimant. However, I was very struck by that case and by the cost to the appellant of having to produce extra evidence.

[32] **David Rees:** I therefore assume that you will be taking those points up with the UK Government.

[33] **Dr Hussey:** Having heard the issue raised this morning, it is very clear that these communities are in great need. We have set out the inequality in health that people experience in Wales in the poorest communities, and we need to ensure that the health service can support people. Through the tackling poverty plan, we have talked about the inverse care law work in health boards, Cwm Taf being one of them. So, we need to look at the longer-term issue, but, immediately, we need to follow up how we can best help people in acute distress. Now, I recognise that GPs are concerned that they have to care for people as well—that is their core responsibility. So, we will take it forward and discuss with the BMA and the local health boards how best we can support people who are, as I say, in particular distress when these issues arise.

[34] **David Rees:** Okay, thank you. I have two Members who are interested in this particular point before I call Rebecca. Elin?

[35] **Elin Jones:** It is not on this point.

[36] **David Rees:** Is it not? Andrew?

[37] **Andrew R.T. Davies:** Just on this specific point, if I may, I appreciate that charging is for many families a huge issue—I do not underestimate that—but, as I understand the letter, it is instructing GPs not to undertake the letter-writing exercise, even when the charge is levied. This morning, there was a case in which someone highlighted how she paid £20 to have the letter provided. Now, you can have the argument with the DWP, but, as I understand it, the instruction that has gone out is not to participate in writing letters of support in any shape or form. Surely, it is for you, as the department, to work with the GPs and the BMA to find out what on earth is going on, because, even if somebody were to offer them £100 for writing a letter, the letter is instructing GPs not to participate in that. It is wrong to try to present the case that these letters are for free; they do incur a charge, and I appreciate that many families will find that charge prohibitive, and that is a point that needs to be argued—that is fair enough. However, the instruction that has gone out is to say that, whatever is offered, people will not participate in supporting the claims. Am I right in saying that?

[38] **Mark Drakeford:** Let us be completely clear: the LMC is not in a position to instruct anybody. It can advise its members, but it cannot instruct them. I want to be completely clear about that—I am not having any LMC thinking that it can instruct GPs; it advises its members, and that is what this letter does.

[39] The issue that Andrew points to, however, is that the reason behind some of this is the sheer volume of work that these GPs now face in the number of letters that they are being asked to write and a feeling on their part, which I do not think that we can just dismiss, that the time that they spend writing letters is time that they otherwise would be able to spend in direct face-to-face contact with patients, providing the service that they are primarily there to provide. So, that is why I said that there are huge unintended consequences of welfare reform. Where, in the Department for Work and Pensions' impact assessment of all of this, was there a paragraph that said, 'And this will lead to GPs in Valleys communities having no time to spend with patients, because they will have to spend all of their time writing letters for people embroiled in this new DWP policy'? That is why I have said that I do not want to act like I think that the GPs do not have something significant to worry about here, but dealing with it in this way is not the way to do it.

[40] **David Rees:** I think the Minister has indicated that he will be talking to the BMA as well.

[41] **Mark Drakeford:** Yes, of course; we are.

[42] **Dr Hussey:** May I, for the sake of clarity, emphasise that my understanding is that GPs do provide the basic report? So, we are talking about the appeals process. They are able to provide the first level. I just wanted to say that so that there is no ambiguity.

[43] **David Rees:** I understand. Producing the basic report is part of the contractual obligation on them.

[44] **Rebecca Evans:** Minister, you have spoken about the £10 million that you will be investing in surgical and ward nurses. Do you have any similar plans to increase capacity within community nursing? I believe that I am right in quoting a recent, or fairly recent, survey from the Royal College of Nursing, which said that only 6% of community nurses feel that they always have enough time to take care of their patients.

[45] **Mark Drakeford:** I would like to make a small number of points on that, Chair, if I could. First, the work that Professor Jean White, the chief nursing officer, has done in developing this acuity tool for medical and surgical wards is part of a wider programme that she is engaged in, which will provide similar tools for nursing in other settings, and community nursing is quite high up on the list of the next phase of her work. I discussed that with her on Monday of this week. So, yes, there are further things to follow in the nursing field, and community nursing is involved in that.

[46] There is a second strand to what we are doing in community nursing, which is to increase the level of education and training courses that are available to people who want to move to work in the community setting. One of the problems we have had in the past is that, in order to support the shift of services from secondary care into primary care, you sometimes have to re-equip people whose basic training was to work in the one setting in order to allow them to work in the other. There is a substantial amount that has gone on in the last few years to increase the level of courses available, and to change the nature of the courses, so that nurses are better able to take modules at points that suit them, to accumulate the knowledge that they get through that, and then to put themselves in a position to take up nursing duties in a different part of the health service spectrum. The greatest growth in the programmes that we have is in the community nursing field.

[47] **Rebecca Evans:** I have one further question on that £10 million investment. Do you expect that to lead to less of a reliance on agency nurses on wards?

[48] **Mark Drakeford:** Yes, I do. We already have, right across Wales, agreed policies to reduce the reliance on agency and bank nurses, and those have been very successfully implemented over the recent period. One of the difficulties that I know the chief nursing officer faced in developing her acuity tool was that it is not always as easy as you might think to know how many nurses there are on a ward at any one time, because of the use of people who are covering, and from agencies and so on. However, one of the things that we are confident of is that the £10 million will allow the taking on of permanent establishment nurses and, as a result, it will reduce—although not eliminate, as there will always be some need to cover for sickness, holidays, and so on—the use of agency and bank nurses.

[49] **David Rees:** Elin has the last question on this topic.

[50] **Elin Jones:** I just wanted to ask the Minister to elaborate, if you will, Minister, on the comment that you made on doctor training places. You said that Dr Hussey had information on the doctor training places and the numbers filled. In particular, could you elaborate on GP training, because we know that the average age of GPs is close to the retirement age? So, could you elaborate on the numbers in GP training and whether those places are being filled?

[51] **Dr Hussey:** The advice that I have had from the deanery is that contrary to previous years, it has had more success this year in GP trainee recruitment. I am sure that we could provide the precise numbers to the committee. However, I am aware that there is a wider primary care workforce issue as to GP retirements and so on. So, part of the work that we are actively involved in is forecasting and looking ahead to make sure that we are planning for the next five to 10 years because of the changing nature of the GP principal workforce. The advice that I got from the deanery some weeks ago was that it had made some good inroads into recruiting GP trainees this year, and that it felt that there was a more positive improvement.

[52] **Elin Jones:** Could we have that information as a committee, and could we have it broken down to areas in Wales? If a doctor trains in a particular area, they will quite often serve that area in later life. The issues around GP training places being filled throughout Wales have been problematic.

[53] **Dr Hussey:** I can ask the deanery to look into that to see what it can provide.

[54] **David Rees:** Thank you very much. We will go on to a different topic now. Kirsty?

[55] **Kirsty Williams:** On the issue of NHS performance, the report published this week by the Wales Audit Office stated that waiting times for planned treatment have significantly worsened over the past three years, that performance in emergency has deteriorated and that the Government has not been able to meet its cancer waiting times targets. I note in the Minister's evidence that plans have been submitted by each of the LHBs to the department, and that they are currently being risk-assessed. Is it your intention to make those plans public? Is it your intention to make the risk assessment of those plans public? You say that

[56] 'levels will be reassessed based on the evaluation of plans and intervention to drive delivery will be provided as necessary.'

[57] Could you outline to us what that intervention will be?

[58] **Mark Drakeford:** Thank you, Kirsty. I will begin by emphasising that, wherever I

go within the NHS, there are a series of core targets that are very important for them to reach, partly as a matter of public confidence, but particularly in terms of cancer waiting times as a matter of clinical urgency. I say that to the service all the time. I am encouraged, in a preliminary way, by the resilience of the NHS in the way that it has recovered from the rigours of a very difficult winter. Over the last three months in unscheduled care, ambulance performance has risen in each of those three months, and accident and emergency performance has risen in every one of those months. I am saying to the service that I expect to see that performance continue.

[59] In relation to cancer particularly, I have been concerned with the figures that I have seen since becoming Minister for health. I have met with senior clinicians and others about the challenges that we face in meeting cancer waiting times. As you know, I try to make the point, because I think that it is a fair point to make on behalf of those working in the service, that more people are seen within the 31-day and 62-day waiting times than ever before. That has been true in recent months as well. However, given that the number of people coming into the system is rising even faster, the percentage performance is affected.

[60] It is a good thing that more people are coming in earlier, because we know that the single biggest difficulty in Wales in terms of cancer treatment is that people do not present themselves early enough for identification. We have done a major piece of work with GPs to equip them better to spot people who may have cancer early in the system. There are plans, in the case of each health board, which will result in the NHS across Wales meeting its 31-day and 62-day targets by October of this year. Some of those plans, it is fair to say, look more robust and resilient than others. At the moment, there is a period of testing of those plans going on between senior officials in the department and the people who have provided them, so that we can be confident that October is a reliable date at which all of this will be achieved and will be sustained. You asked about whether these plans will be published. My own starting point is that the more that there is in the public domain, the better people understand what is going on. I will check the basis on which people have provided the information, but my starting point is that I would rather that these things were out there and known, rather than sitting in the drawers of people who are in some sort of inner circle.

10.00 a.m.

[61] **Kirsty Williams:** That is great. So, if you publish those plans, will we also see the risk analysis that your department has carried out alongside them? Could you also outline what is the nature of the intervention that you have promised on page 3 of your evidence to this committee, if LHBs do not perform against those plans?

[62] **Mark Drakeford:** In terms of the risk assessment, I will think about that. My aim is to have plans where we have a shared confidence that the risk of them not achieving it has been reduced to a point where we are sure that they will be achieved. I know that there may be a wider interest in the way that escalation procedures operate. It is an operational rather than a ministerial-led system. I will ask David Sissling to just outline it for members if you like, so that the way that it is operated is clear. Then I will answer any questions that you have.

[63] **Kirsty Williams:** Brilliant.

[64] **Mr Sissling:** The first thing to say is that this would apply not just to the areas that have been identified as being in need of improvement—cancer, unscheduled care, aspects of elective care—but equally to make sure that we sustain improvement in those areas where it has been acknowledged that—and this was in the report earlier this week—there has been a pattern of improvement, for example in mortality rates, stroke and infection management. We want to make sure that we have the path of improvement in all areas and that we keep what is

good going in a good direction. However, in those areas where there is a need for action, it is clear what that action is.

[65] The process is that we ask the health boards for plans and then we risk-assess the plans and we grade them. We advise the health boards when they are over the line, but, if they are not, we ask them to address the plans, and, at times, we ask them to take advantage of other health boards, because clearly if there is good practice in health board A, we would want that to be shared with health board B. At times, we provide health boards with opportunities to access external advice to make sure that we can sign off their plans.

[66] If there is non-delivery of a plan, then there is a very clear process of escalation set out in the delivery framework, which would provide the opportunity for us to mobilise very regular reporting, in terms of monitoring it more closely. We will introduce a requirement for our delivery unit to go to work with the health board in question. This would be a team of people—clinicians, managers and information analysts—who can go to work to help them in a diagnostic sense to identify the problems and to allow them to refresh and strengthen their plans. At any point, our delivery unit is working in a number of health boards on a number of issues. Quite commonly, it will be those issues that you talked about.

[67] Clearly, at some point it can move into the performance management arrangements. We would take up our concerns with the health board in a formal way to make sure that the leadership was paying attention to the issue and that there was the follow-through into improvement that we would want to see. It applies across everything. Our interest is in making sure that what is good is maintained and improved, as well as those areas that are more concerning.

[68] **Kirsty Williams:** I have two questions, then. The Minister has made a very clear commitment on the ability to meet the cancer targets by October 2013. Are you able to give us a date by which you would expect the Government's own A&E targets to be met and the Government's elective surgery targets to be met? If you are able to do it for cancer, are you able to give us dates for the other two?

[69] **Mark Drakeford:** In relation to A&E targets, the performance has improved in each of the last three months. It is being achieved and sustained now in some parts of Wales. Bronglais, astoundingly—no, that is the wrong word [*Laughter.*—]outstandingly, has achieved compliance above the level that we set. What I say to health boards all the time is that they have got to make that next push to get to that figure, because of the focus that is on it and—

[70] **Kirsty Williams:** I know what you are saying to them, Minister; I want to know when they are going to do it.

[71] **Mark Drakeford:** I wish that I could just pluck a month out of the year for you and say that it will be done by then, but I am not in that position. However, I am encouraged by the trend, and I expect the trend to continue. On that particular point, one of the reasons why I say that it is so important for health services to do this is that I have undertaken a lot of visits to A&E departments since becoming Minister, and a very large majority of staff—certainly not all, but a very large majority—to whom I speak in A&E say to me that this four-hour target is perverse. It drives all sorts of consequences that you would not want to see and it is a very blunt instrument indeed. They say to me that, from a clinical perspective, there is a better way of configuring these targets. I say to them that I would like to be able to do that with them—I would like to be able to have that conversation with them. However, we need to have that conversation when we get to a point where we are confident that we are able to do what we are currently attempting to do.

[72] **Kirsty Williams:** I welcome that approach very much. I have one final question. Mr Sissling, you said that you have a delivery unit that helps identify the problems in meeting targets at LHB level. In this week's report, it said that your own department needed to have a better understanding of the issues that were driving the failure to meet targets. Could you outline for us what you are doing, in your department, to meet the challenges in the audit office's report about your own ability within the department to understand what is driving failure?

[73] **Mr Sissling:** I think that that really stemmed from the experience that we had with unscheduled care over the latter part of 2012 into 2013, when we had, like all other parts of the UK, unprecedented demand and a different profile of demand; the demography seemed to be changing. We had a relatively steady number of admissions compared with previous years, but the length of stay increased. That caused there to be higher occupancy and a need to cancel elective operations, because beds were occupied by patients who had been admitted as emergencies. That has been the work that we have been doing—to understand and analyse that—over the last number of weeks. We are now very clear, I think, about those particular issues. That has been the response, regarding that particular comment, so that we can understand, in the delivery part of the department, exactly how we can provide help and advice to health boards, and how we can introduce the right kind of support to them in the context of what seems to be a changing pattern of demand.

[74] **David Rees:** I wish to ask a question on unscheduled care. I am going to include unscheduled care, not just A&E, because in April the Minister made a statement on unscheduled care, and this is about a wider range of services. Clearly, we saw the unprecedented requirements over winter, which might happen this summer because the heat is causing as many problems as the cold, in one sense. However, when will you be in a position to give this committee an indication that you will be ready for next winter? We want to be sure that the Government has put itself in a position where it has everything in place so that it is prepared for coming times.

[75] **Mark Drakeford:** Absolutely; that has been a top priority for me since the very beginning—that the NHS uses what is a slender opportunity, but an opportunity nonetheless, of the period from May to September to prepare itself. Somebody once said to me that the problem with the NHS is that it is always taken by surprise by November. We really cannot be taken by surprise by it this year. We have to do everything that we can to prepare for the fact that we will face demands and pressures again next winter. None of us can predict what the weather will be like. In March of this year, the temperature was half what it was the previous March, which was a big reason why the demand was what it was.

[76] I asked, in the very first week that I was Minister, for plans to come in from health boards, signed jointly with the ambulance service, as to how they were going to meet the pressures immediately and how they were going to plan for next winter. We have an unscheduled care group chaired by Dr Chris Jones that is working on this as well. We keep in very close contact with local health boards and social services departments. If I have been cheered up at all by things over the last few months, it has been by some well-argued and detailed reports that I have received, jointly signed by the leading players in health boards and social services departments in their areas, showing how they are preparing for the next winter.

[77] **William Graham:** May I ask some questions on both health and social care? Clearly, the committee has heard a lot of evidence on supporting integration and has welcomed that. What you are saying is that you intend to provide adequate support for frail, older people who are cared for at home, which, again, is generally to be welcomed. My question is about those people who have that facility at the moment, but who have deteriorated mentally to such an extent that the treatment and care is pretty minimal, but it does exist. You are suggesting that it is going to take some time—you say that it will be March 2015 before you will be capable

of meeting a 24-hours-a-day service, which we understand as there are other priorities. My question is also linked to your mental health strategy: for those people who have severe mental capacity issues, how are you going to reach them? In two ways particularly, one is that it is necessary to have a multidisciplinary approach. For many of us, we find that the GPs have not entirely bought into that, particularly in terms of the training of their staff, where you have a patient, as I described, and the carer rings and the first thing that they are asked by the surgeries is whether they can bring the patient to the surgery. That is a nightmare scenario for the carer. Do you understand where I am coming from? How do we improve those services? There are an awful lot of people who will become or are already in that category.

[78] **Mark Drakeford:** I will make a start and Gwenda may want to add things from the social services perspective. I recognise very much the issue that you raise. On the Mental Health (Wales) Measure 2010, which we are implementing, I am pleased to say that when I go out and talk to people who are involved in it, it continues to have a strong reputation, both as a piece of legislation and also in terms of how it is being implemented on the ground. The first part of that Measure is all about strengthening primary care and provision at that primary care level. There is sustained investment over the period ahead to continue to support that. It relies on a multidisciplinary approach—that is at the heart of the way in which the Measure thinks about the needs of people who have mental health problems. The strengthening of community psychiatric nurse provision, as part of a primary care team, ought to mean that when there is a need to respond to the needs of people where they live, we are better able to do that in the future. I am quite sure, as William Graham said, that it does not happen everywhere, consistently, to the level that we would hope and will expect increasingly. I think that the mental health Measure is a bit of a journey and the strengthening of primary care is not something that we are going to achieve in the very first year of it, which is why the money continues well beyond that. However, the basic premise that you set out—a wider range of services, delivered closer to where people live, and responding to some very challenging circumstances that can happen very quickly sometimes with people who suffer from a mental health condition—is the way that those services need to be provided.

[79] **Gwenda Thomas:** I made four leaflets available to the committee. One of them was on care plans and another was on assessments and eligibility. The Social Services and Well-being (Wales) Bill quite clearly states that care planning will have to take into account the totality of the needs of the service user. In other words, in developing the care plan, there will have to be due recognition of a mental health need—a special educational need, for example—and that will be a statutory requirement under the Bill. It needs to be multidisciplinary and needs to work within the national dementia plan, which we know is becoming well embedded. With regard to assessments, there is a statutory obligation in the Bill for assessments to be subject to regular reviews. That is intended to capture deterioration in a person's condition, which is very important, I think.

10.15 a.m.

[80] Also, with regard to taking the service user to the surgery, the Bill—for the first time—will give carers the same rights as the people that they care for. I think that, in assessing the needs of the carer and care plans for carers, the need to transport the service user must be part of that in my view.

[81] **William Graham:** Thank you for those answers. Just touching on that, particularly in terms of the mental health strategy, how do you hope to be able to develop that further, particularly for people still at school age? We had anecdotal evidence that the wait for a clinical psychologist is longer than it should be, and that it varies from borough to borough. How do you hope to develop that further? Clearly, it is a time of financial restraint. I cannot expect you to say that we are going to put large sums of money into it, but it comes back to the early intervention part.

[82] **Mark Drakeford:** It does. I think that there are a number of key principles that need to underlie our child and adolescent mental health strategy, and I think that they are, by and large, the ones that people work to across Wales. First of all, I think that I am in favour of a maximum diversion approach. To bring a young person into the mental health world at a young age is a very serious step indeed to take, and it is a step that will live with them throughout the rest of their lives. I think that we have to be very careful when we decide that mental health services, in that specialist sense, are the right way to respond to a young person's needs. There may well be other things that are available to all young people that, if they were provided in a better or more direct way, would allow that young person to grow through whatever difficulties that they are facing. As you know, I have worked, in the past, as a probation officer and as a social worker. I am very well used to parents saying to me, 'He needs to see a psychiatrist, Mr Drakeford', and I think, 'Well, actually, what he needs is a bit of a chance to grow up'. So, medicalising children's behaviour in that way, I think, is a serious thing to do, and we need to think carefully about it.

[83] When you do need to intervene—and there will be cases where you need to intervene—it is the minimum necessary that you need to do. There is a danger in all services of this sort that, once they have got you, they tend to drag you more and more into them. Again, for children and young people, particularly, that is a danger that we must be alert to. So, you want to do what is necessary, but you need to do it at the lowest possible level consistent with that need. That is why we have a tiered approach to mental health services.

[84] Finally, you need to think about the way that you manage the whole system, rather than to expect the individual to adapt to the system, which, again, I think is a bit of a characteristic of some of our public services. There is a system, the person arrives and they are just sort of processed through it. It is better to look at the way that the system can be adapted to meet the needs of the individual, rather than expecting the individual to adapt to the needs of the system. I think that that is particularly true, again, in child and adolescent mental health.

[85] There are a number of principles that we can use. I think that that would lead to some reallocation of resource within the mental health field, so that we get more to people who really need the most and we divert those young people whose needs might be able to be met in a more 'normalised' and less intrusive way.

[86] **David Rees:** We will have Gwyn next, followed by Andrew and Elin.

[87] **Gwyn R. Price:** Just going back to the weather taking us by surprise, I would just like to ask the medical officer a question. I see that there are financial restricts, but with the heat wave now upon us, do you regret taking that decision?

[88] **Dr Hussey:** The heat wave system was developed in the 2005-06 period as people started to realise that heat was a potential cause of poor health in the same way that cold weather had been recognised to be so. Therefore, it is fair to say that the planning system has developed over that period. So, now, we are in a position where people are very well aware of the importance of heat and the actions to take. The system that we have in Wales is that the emergency response teams and the local health boards have heat wave plans. They have been reminded about those this year and are well aware of the response they need to make as the temperature changes, because it varies across Wales, so it is a tailored response to the local circumstances. I have personally issued hot weather advice in the last couple of weeks, reminding people of the steps they can take to look after themselves in warmer weather. It is fair to say that the last heat wave in Wales, as I understand it, was 2006. So, the system that we are talking about was, if you like, another type of alerting system, but, over the last few years, the system has changed and people are well aware and there is much more public

information. The Met Office itself can provide, on request to local agencies, a regular feed advising them on the local conditions for themselves. It was in discussion that decisions were made.

[89] **Mark Drakeford:** To be completely clear on the chief medical officer's behalf, it was my decision, not the chief medical officer's. Do I regret it? No, I do not. Money is very short indeed in our public services. We were spending £25,000 a year for information that you can get by turning on the radio. The advice I had was that, since the service was originally developed, there is a much wider range of ways in which this information is available and neither Scotland nor Northern Ireland were part of the system. I feel very comfortable indeed that, when money is short, £25,000 spent on something that you can get very easily without spending that money, gave me £25,000 to spend on something that was much better value for the NHS.

[90] **Andrew R.T. Davies:** Minister, there has been much talk over the last couple of years and more recently about GP and consultant contracts. One could almost look back and say that they were very generous when they were issued in the early 2000s. The committee today has taken your evidence on waiting times and the general operation of the health service. However, at the heart of this is that if some of the key players have very restrictive practices that these contracts have enshrined, it makes it very difficult for administrators to remodel services and meet the aspirations of their communities in the best way possible. Do you support the change that is being championed at the other end of the M4 to some of these contracts, or do you believe that the current contracts offer the flexibility that the Welsh health service requires, both at GP level and at consultant level?

[91] **Mark Drakeford:** I thank Andrew for that question, because it is a very important question about potential decisions for us to be thinking about in Wales in the coming months. The question is often put to me in the way of, 'Do you think that we should have a UK contract still, or are you going to go for a Wales-only contract in this?' I generally say that that is not the way that I approach the question. The way I approach the question is: 'How can we get the best deal for Wales and the right arrangements that we need for the Welsh NHS?' If, as the UK discussions continue, I come to the view that sticking with the UK arrangements will provide us with what we need for Wales, then I would do it that way, and if I thought that it did not, and we needed a Wales-only solution, then I would be more inclined to go for a Wales-only solution. I am not so much interested in the means as I am in getting the right end—the right answer at the end of it.

[92] We have generally, and for good reasons, felt that UK contracts are a better way of doing things. The workforce is very mobile. It moves across the border all the time. We need, as we heard earlier, to be able to attract the best people to come to work and live in Wales, and common contractual arrangements have, in the past, been thought to be an important part of allowing us to do that. So, I do not move away from a UK arrangement lightly because I think that there are things that we give up, as well as things that we might gain. We have moved away from it once in the past. We have a Wales-only consultant contract because, in 2003, the contract that was available on a UK basis was one that we did not feel best met the needs of Welsh patients. So, there are negotiations to be had and discussions have already started with the BMA and others. We continue to be part of the UK arrangements too, although I think it would be fair to say that our role at the UK table tends to be one more of observation than a very active, participatory role. However, as the months move on, there will be some important decisions to be made that go to the heart of the question that you have asked. I will want to see contractual arrangements in Wales that provide a proper balance between the proper rights of people who work in the NHS and the provision of the sort of service that we will need in the future, and that will require a more flexible workforce that is able to provide the sort of services that we talk about here a lot—services that are closer to people and are more out-of-hospital than in-hospital, and so on—and I look forward to being

able to continue to have some of the discussions that we need to have across the table here about getting the best set of arrangements Wales.

[93] **Andrew R.T. Davies:** Thank you for that detailed response, but the current contract does not offer you that flexibility and the ability to move forward, both in the primary sector and in the acute sector. So, change is inevitable.

[94] **Mark Drakeford:** I do not believe that we have exhausted the flexibilities that are available within the current contracts. So, I do not want to say that I think that there are straitjackets and that we therefore have to tear the contracts up and start again. I have, for example, said—and I am very happy to repeat it here—that I think that there are better ways in which we can deal with the quality and outcomes framework component of the GP contract, which, in some parts, has become a sort of accountant's way of thinking about practice, you know—you see somebody, you do it, you tick the box, you get the money. I would like to move a step or two back, in the direction of professional trust and professional judgment. I think that GPs might be able to provide a better service if they could decide what the holistic needs of their patients are, rather than calling people back month after month in order to give them this test and that, just so that they can fulfil the QuOF requirements. So, I think that there are some flexibilities that we could extract from the current arrangements. Whether they are sufficient to put us in a position we really want to be in is a less concluded question, I think.

[95] **David Rees:** I have one supplementary question on this particular point from Leighton, and then we will move on to Elin's questions.

[96] **Leighton Andrews:** Do you think that the current contract gives you the flexibility you need to innovate, for example, in relation to salaried GPs? Also, how do you feel about more financial transparency in the amount of NHS money going into each individual GP practice?

[97] **Mark Drakeford:** I do not think that the contract prevents us from providing salaried GPs. Leighton, you will be particularly aware that, in the Cwm Taf area, as it now is, we have had a whole cadre of young, salaried GPs coming into that area. We have talked already this morning about the age profile of GPs in the sense that there is a big wave of retirements coming up. Quite a few of us at the table here will remember the early days of the Assembly when we were very preoccupied with a similar pattern of retirements among a wave of people who had come to work in primary care in the Valleys in the 1960s. There were dire predictions that we would not be able to provide a primary care service there. To some extent, that was significantly solved by employing salaried GPs, who, in quite large numbers, have gone on to take up positions in the more conventional way that GPs organise themselves. So, I do not think that the contract is the primary difficulty in relation to recruitment in that way.

[98] Should we have more openness in the way that we publish information at practice level? Quite often, I think, what happens in the health service is that we publish a vast amount of information, but we do it in a very inaccessible way. Somebody said something to me the other day—I think it was someone who had written to me, asking me about information, and I replied in one of the letters that you get to reply, saying, 'This information is already available to you on the NHS website', and they replied to me to say that they had eventually found it, and it was 14 mouse clicks away from where I had told them to start. [*Laughter.*] So, you know, it is there, but you have to work very hard and be pretty knowledgeable to get it. I have a feeling, without being quite close enough to the detail, that quite a lot of that information could be obtained now if you knew the best way to get it. However, I am quite happy to think about the points that you have made and to see what—

10.30 a.m.

[99] **Leighton Andrews:** I do not want to get mouse thumb. [*Laughter.*]

[100] **Mark Drakeford:** No, indeed.

[101] **David Rees:** Thank you, Minister. Elin is next.

[102] **Elin Jones:** Diolch, Gadeirydd. Rwyf eisiau gofyn ychydig o gwestiynau ynglŷn â phrosesau ailgyflunio, yn benodol yn ne Cymru ar hyn o bryd. Mae'r pwyllgor wedi gwneud rhywfaint o waith yn y gorffennol gyda Betsi Cadwaladr a Hywel Dda. Yn gyntaf, beth yw rôl y fforwm clinigol cenedlaethol yng nghyd-destun y broses o ailgyflunio yn ne Cymru? A gaf ofyn i chi wedyn ynglŷn â'r broses nawr wrth symud ymlaen o'r ymgynghoriad cyhoeddus sydd yn cau'r wythnos hon yn ne Cymru? Mae pedwar cyngor iechyd yn rhan o'r broses honno. Beth fydd y broses wedyn? A fydd y pedwar cyngor iechyd yn gorfod cytuno ar argymhellion y byrddau iechyd ar y cyd? Felly, a yw'r canllawiau i'r cynghorau iechyd yn ddigon clir ynglŷn â chydweithio a chymbenderfynu?

Elin Jones: Thank you, Chair. I want to ask a few questions in relation to reconfiguration processes, specifically in south Wales at present. The committee has done some work in the past with Betsi Cadwaladr and Hywel Dda. First of all, what is the role of the national clinical forum in the context of the reconfiguration process in south Wales? May I also ask you about the process now moving on from the public consultation that closes this week in south Wales? There are four health councils that are part of that process. What will the process then be? Will the four health councils have to agree on the recommendations of the health boards jointly? Therefore, are the guidelines for the health councils sufficiently robust in relation to collaboration and joint decision making?

[103] Y cam nesaf, wrth gwrs, yw y gall y cynghorau iechyd beri bod y mater yn cael ei benderfynu, oherwydd anghydweld yn lleol, gan Weinidogion Cymru. Mae'r rhan fwyaf o Weinidogion Cymru yn cynrychioli de Cymru ac felly a yw'r Llywodraeth wedi dod i unrhyw benderfyniad ar hyn o bryd ynglŷn â pha Weinidog a fydd yn cymryd y penderfyniadau ar dde Cymru?

The next step, of course, is that the health councils can trigger a decision on the matter, because of local disagreement, by Welsh Ministers. The majority of Welsh Ministers represent south Wales and therefore has the Government reached any decision at present in relation to which Minister will take the decisions on south Wales?

[104] Mae gennyf bwynt arall o ran prosesau a'r byrddau iechyd. Mae pwyllgor arall yn y Cynulliad heddiw yn edrych ar yr adroddiad ar y cyd rhwng Arolygiaeth Gofal Iechyd Cymru a Swyddfa Archwilio Cymru ar Betsi Cadwaladr. A ydych o'r farn y dylid cael adroddiadau ac ymchwiliadau tebyg ar gyfer pob bwrdd iechyd yng Nghymru, achos mae nifer o faterion dadleuol a phellgyrhaeddol iawn wedi cael eu hamlygu yn yr adroddiad ar Betsi Cadwaladr? A ydych yn credu bod y broses honno o edrych ar waith bwrdd iechyd Betsi Cadwaladr wedi bod yn fuddiol? A fyddai'n fuddiol i wneud yr un gwaith a'r un adroddiad ar y byrddau iechyd eraill?

I have another point in relation to processes and health boards. Another committee in the Assembly is looking today at a joint report by Healthcare Inspectorate Wales and the Wales Audit Office on Betsi Cadwaladr. Are you of the opinion that similar reports and inquiries should be undertaken of every health board in Wales, because there are a number of controversial and very far-reaching matters that have been made evident in the report on Betsi Cadwaladr? Do you believe that that process of reviewing the work of the Betsi Cadwaladr health board has been beneficial? Would it be beneficial to do the same work and the same report on other health boards?

[105] Rydych wedi dweud tipyn, y bore You have also said a great deal this morning,

yma, Weinidog, ynglŷn â gwybodaeth a phwysigrwydd ei fod ar gael ac yn *accessible* i bobl, ac rwy'n cytuno â phopeth rydych wedi ei ddweud ar y cwestiwn diwethaf ynglŷn â *GP practices* yn benodol. Rwy'n credu efallai bod llawer y gellid ei ddysgu o'r gwaith gan arolygiaethau yn y sector addysg a'i drosglwyddo i'r sector iechyd. Rydym yn gwybod bod Estyn yn gwneud gwaith ar arolygu ysgolion a chyhoeddi hynny. Mae hynny'n gyhoeddus. Mae'r ysgolion a ni i gyd fel Aelodau Cynulliad yn cael yr adroddiadau hynny wedi eu hanfon atom. Nid wyf yn gweld yr un math o beth lle mae Arolygiaeth Gofal Iechyd Cymru neu gynghorau iechyd yn arolygu; ryw ffordd, nid yw'n cael ei gyhoeddi a'i drafod yn gyhoeddus yn yr un ffordd. Mae'r adroddiadau hynny'n bodoli, ond mae pobl yn gorfod chwilio amdanynt. A ydych yn credu ei fod yn bryd creu system ar gyfer arolygu sydd yn llawer mwy cyhoeddus fel bod, yn dilyn Francis, gwybodaeth a thrafodaeth gyhoeddus ynglŷn â safonau mewn ysbytai? Byddai hynny'n help i wella safonau yn gyffredinol. A yw'n amser i wneud rhywbeth mwy cyhoeddus ar hynny?

Minister, about information and the importance of its availability and accessibility to people, and I agree with everything that you said on the previous question in relation to GP practices specifically. I think that there is a great deal that could be learned from the work by inspectorates in the education sector and from transferring that into the health sector. We know that Estyn does work on inspecting schools and publishes that. That is publicly available. The schools and all of us as Assembly Members receive those reports. I do not see the same thing happening where Healthcare Inspectorate Wales and health councils are inspecting; somehow, it is not published and discussed publicly in the same way. Those reports exist, but people have to look for them. Do you think that it is time to develop a system in relation to inspection services that is much more public so that, following on from Francis, there is public information and debate about standards in hospitals? That would help to improve standards in general. Is it time to do something more public on that?

[106] **David Rees:** Minister, there were several questions there. We have limited time left, so, if you could be succinct in your answers, I would be grateful.

[107] **Mark Drakeford:** Rwy'n ymddiheuro, i ddechrau, os byddaf yn anghofio un neu ddau o'r cwestiynau. I ddechrau gyda'r fforwm clinigol cenedlaethol, fforwm i'r byrddau yw. Nhw sydd wedi sefydlu'r fforwm, ac mae'n eu cynghori yn y gwaith maen nhw'n ei wneud. Mae'r fforwm clinigol cenedlaethol wedi cynghori byrddau de Cymru am y gwaith maent yn ei wneud yn barod. Rwy'n gwybod eu bod wedi bod lan a lawr. Yr hyn mae'r fforwm yn ei wneud yw cynnig rhyw fath o sialens i'r byrddau i fod yn glir eu bod yn dod ymlaen ag awgrymiadau a fydd yn sefyll lan i'r *scrutiny* y bydd y broses yn ei rhoi iddynt.

Mark Drakeford: I apologise, first of all, if I forget one or two of the questions. To start with the national clinical forum, it is a forum for the boards. They have established the forum, and it advises them in the work that they do. The national clinical forum has advised the south Wales boards about the work that they are already doing. I know that they have been up and down. What the forum does is to offer some kind of challenge to the boards to be clear that they come forward with recommendations that will stand up to the scrutiny that the process will give them.

[108] Rwy'n mynd i droi at David Sissling mewn moment er mwyn bod yn glir am y broses cynghorau iechyd cymunedol. Fel rwyf yn deall y broses—bydd David yn gallu gwneud hyn yn glir—ar ddiwedd y broses bydd yn rhaid i bob bwrdd ystyried yr hyn sydd wedi dod o'r broses a gweld os oes modd iddynt gytuno ar y ffordd ymlaen. Mae

I will turn to David Sissling in a moment to be clear about the community health councils process. As I understand the process—David will be able to clarify this—at the end of the process every board will have to consider what has come out of the process and see whether they can agree on the way forward. It is up to every community health council to

lan i bob cyngor iechyd cymunedol wneud yr un peth hefyd. Felly, nid ydynt yn dod at ei gilydd fel un bwrdd—maent yn ei wneud ar wahân achos mai ganddynt gyfrifoldebau cyfreithiol gwahanol. Fodd bynnag, bydd Mr Sissling yn gallu cadarnhau a yw hynny'n gywir. Mae i'r Prif Weinidog ddewis y person sy'n gyfrifol am bethau os yw rhywbeth yn dod mewn i'r Gweinidogion, ac mae wedi dweud hynny'n barod. Rwy'n meddwl ei fod yn aros i weld os bydd rhaid gwneud hynny a bydd yn gwneud y penderfyniad pan fydd yn gwybod yr hyn sydd ar fwrdd unrhyw Weinidog yn y dyfodol.

[109] Roedd y cwestiwn olaf ynglŷn â chyhoeddi pethau. Rwy'n cytuno â'r hyn yr ydych yn ei ddweud. Mae lot o bethau yno yn barod. Mae Arolygiaeth Iechyd Cymru yn cyhoeddi bob adroddiad mae'n ei gynhyrchu, fel ag y mae bob cyngor iechyd cymunedol. Fodd bynnag, nid yw'r broses yn tynnu sylw at beth maent yn ei wneud, fel ag y mae pan mae Estyn yn cyhoeddi pethau. Felly, rwyf yn hollol fodlon siarad â'r arolygiaeth a'r cynghorau i weld a oes unrhyw beth arall maent yn gallu ei wneud i dynnu sylw at y gwaith maent yn ei wneud. I fod yn glir, mae'n hollol agored iddynt siarad â phobl am y gwaith maent yn ei wneud.

[110] **Elin Jones:** Dim ond un cwestiwn y gwnaethoch ei fethu, sef yr un ar yr arolygiaeth ar y cyd a chymryd y model a ddatblygwyd ar gyfer Betsi Cadwaladr a defnyddio hynny ar gyfer byrddau iechyd eraill.

[111] **Mark Drakeford:** I fod yn glir, cyrff annibynnol ydynt. Nid wyf i fel Gweinidog yn dweud wrthynt fy mod eisiau iddynt fynd i mewn i Betsi Cadwaladr, neu beth bynnag. Daethant ataf i i ddweud, achos eu bod yn gwneud y gwaith hwnnw yn barod, roeddent yn meddwl y byddai'n ddefnyddiol iddynt ddod at ei gilydd a gwneud adroddiad ar y cyd, fel ag y maent wedi ei wneud. Mae ganddynt bwerau annibynnol i wneud pethau felly, ac nid wyf eisiau mynd mewn i bethau fel hynny. Rwy'n credu eu bod yn bwysig iddynt ddweud wrthyf i—nid gofyn i mi—eu bod yn meddwl bod yn rhaid iddynt fynd i mewn i rywle, ac maent yn gallu gwneud hynny yn unrhyw le yng Nghymru pan maent

do the same as well. So, they do not come together as one board—they do it separately, because they have different legal obligations. However, Mr Sissling will be able to confirm whether that is correct. It is up to the First Minister to choose the person responsible for things if something comes in to Ministers, and he has said that already. I think he is waiting to see whether there will be a need to do that and he will make the decision when he knows what is on the table of any Minister in the future.

The last question was on publishing things. I agree with what you said. There are many things there already. Health Inspectorate Wales publishes every report that it produces, as does every community health council. However, the process does not draw attention to what they do, as it does when Estyn publishes things. So, I am perfectly happy to talk to HIW and the councils to see whether there is anything else they can do to draw attention to the work that they do. To be clear, it is entirely open to them to talk to people about the work that they do.

Elin Jones: You only missed one question, which was about the joint inspectorate and taking the model developed for Betsi Cadwaladr and using it for other health boards.

Mark Drakeford: To be clear, they are independent bodies. As Minister, I do not tell them that I wish them to go into Betsi Cadwaladr, or whatever. They came to me to say that, because they were already doing that work, they thought that it would be useful for them to come together and to produce a joint report, in the way that they have done. They have independent powers to do such things, and I do not wish to get involved in such matters. I think that it is important for them to tell me—not ask me—that they think that they should go in somewhere, and they can do that anywhere in Wales when they think that there is a need for them to do so.

yn meddwl bod yn rhaid iddynt wneud hynny.

[112] **David Rees:** Rebecca is next, followed by Lynne.

[113] **Rebecca Evans:** I have some specific questions relating to reconfiguration in the Hywel Dda area. You have asked officials to establish a scrutiny panel to consider the issues. What is the composition and remit of that scrutiny panel, and, when it comes time to make a decision, how will you decide, where there is a divergence of opinions expressed locally from the CHC and the health board, and when can we hope for a ministerial decision?

[114] **Mark Drakeford:** I thank Rebecca Evans for that. I can let Members know this morning that we now have a panel in place, and I will be writing to the three party spokespeople about this later today or first thing tomorrow morning, just to put the names formally on the record. However, I can let Members know today that the scrutiny panel will have three members. It will have Mr Jim Wardrope, a consultant in accident and emergency medicine in Sheffield, and a former president of the College of Emergency Medicine. The second member will be Professor Neena Modi, a professor of neonatal medicine at Imperial College London. She is the vice-president of the science and research stream at the Royal College of Paediatrics and Child Health, and the national president of the Neonatal Society. The third member will be Dr David Salter, whom a number of Members here will know, and who is the relatively recently retired former deputy chief medical officer for Wales. He brings an extensive knowledge of the Welsh NHS to that panel. Their remit is being finalised at the moment. I am anxious for both the CHC and the local health board and, indeed, the members of the panel, have the chance to make a contribution to finalising that remit. However, essentially, their remit is to advise me on the two issues that are now on my desk as a result of the Hywel Dda process. I am not asking them to start from scratch on these issues; I am asking them to review the substantial amount of evidence that has accumulated during that process on those two issues and to advise me as to the best way to resolve the outstanding matters.

[115] I have asked them to work over the summer. I said when I was appointed that, among my top three hopes were to bring the existing three reconfiguration exercises to a conclusion. I was very pleased yesterday to be able to announce that the north Wales issues that had been referred to me have been agreed locally. So, that is done. My ambition is to make a statement in the first week that we return as an Assembly in September, because I believe that bringing this to a conclusion is very important for people locally to be able to get on with whatever those decisions turn out to be.

[116] **Lynne Neagle:** I wanted to ask first about neonatal provision. Your report deals with the situation in north Wales, but, as you know, there have been long-standing concerns about neonatal provision across Wales. Could you give us an update on how you feel health boards across Wales are performing in relation to the neonatal standards?

[117] My second question is on the staffing level of paediatricians. You will have seen at the weekend that the Royal College of Paediatrics and Child Health issued a pretty stark warning about the problems that it felt were occurring across the UK, including significant numbers of child deaths, as a result of not having the appropriately qualified staff available on wards. Have you considered what it said, and can you offer any assurances about our staffing levels in Wales?

[118] **Mark Drakeford:** I will probably ask Ruth to add some detail. I rely on the advice of the neonatal network for progress in this area in Wales. It published its latest capacity review in February. It suggested that we needed two extra cots in Cwm Taf and in Cardiff. The process of considering those bids is currently under way.

[119] In relation to recruitment, as I said, I think, in answer to Andrew earlier, I fully recognise that there are a number of specialist areas where recruitment continues to be a challenge, both in Wales and in the rest of the UK. The most recent figures that I have seen for the last three months of recruitment suggest that, while we continue—or, rather, should I say, while we have made no further inroads into appointing accident and emergency consultants, we have managed to reduce the level of vacancies in paediatrics and in psychiatry. So, there has been some progress over the last quarter in that way. Underlying the point that you raised, of course, is the argument that we make continuously and which I believe has lodged in the minds of the Welsh public in general—although, of course, whenever there is a specific proposal that affects them, people understandably feel differently. However, the general case is now well understood that behind some of those figures and concerns lies a need to concentrate our expertise for these very specialist areas and for these very sick children, in some cases, in places where you are guaranteed not just to have the best care that is available locally, but the best care that there is. When you put that to parents and ask what they would prefer, they always come to the conclusion that people around this table would come to. So, underlying it is the fact that it is part of the big picture of the way in which we are trying to reconfigure health services in Wales. However, Ruth may have some more information.

10.45 a.m.

[120] **Dr Hussey:** I would just like to emphasise that the neonatal network is paying very close attention to this and quality has to be the driving factor through this. However, you mentioned the wider review of child deaths more generally. We have a good system of reviewing childhood mortality in Wales, and the report published just recently sets out the wider context of children's health in Wales as well; that is another aspect. For me it is about both prevention and quality. We must keep a twin-track focus on those for child health. It is an area that we are looking to develop to further our understanding of the outcomes that we are trying to achieve and so on. The assurance that I can give you is that this is receiving regular attention to ensure that we are doing the best that we can.

[121] **David Rees:** Thank you, Minister and Deputy Minister, for your answers this morning. We have come to the end of the first session. I also note that, since taking the post, you have initiated several initiatives, Minister, on which we will keep a close eye. Many of the issues that normally come up in general scrutiny have been addressed, with regard to some of the points that you have made during the last few months, and we will keep an eye on how that work progresses. It is important to see how things happen. I also thank Dr Ruth Hussey and Albert Heaney for their involvement this morning, because they are not coming back for the next session; thank you very much.

[122] I would now like to break for approximately 15 minutes, under Standing Order No. 17.47. We will recommence the meeting at 11.00 a.m.; thank you very much.

*Gohiriwyd y cyfarfod rhwng 10.46 a.m. ac 11.00 a.m.
The meeting adjourned between 10.46 a.m. and 11.00 a.m.*

**Craffu ar Waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r
Dirprwy Weinidog Gwasanaethau Cymdeithasol—Craffu Ariannol
Scrutiny of the Minister for Health and Social Services and Deputy Minister for
Social Services—Financial Scrutiny**

[123] **David Rees:** I welcome everyone back to the second part of this morning's scrutiny session. I welcome Martin Sollis who has joined us for this session. We will go straight into

the questions and I will ask the first one.

[124] Minister, you have seen the Wales Audit Office report that came out this week, which highlighted the fact that the NHS in Wales came within budget, but that it faces some great difficulties and that some of the savings were unsustainable. Are you confident that it will continue to come within budget in the forthcoming financial year?

[125] **Mark Drakeford:** I will just start by agreeing with what you said to begin with, Chair, in that the headline finding of the Wales Audit Office report is that the Welsh NHS lived within its means. When you recall the hoo-hah there was a year ago when it very marginally failed to do that, you can see what a significant achievement that was. Will it live within its means this year? There are two things to consider: first, there is a legal obligation on local health boards to live within their means every year. It is not an advisory regime that they live within; it is an obligatory regime. Secondly, as you will know, I have been able to say that, together with the Minister for Finance, we are going to carry out a review of the health budget over the summer to make sure that it is Francis-compliant. There are a number of additional challenges that the health service faces in order to make sure that it meets the Francis agenda, and we will want to look at the budget against that. By the end of the year, the health service will have to live within the money that it has available to it.

[126] **Kirsty Williams:** As you said, Minister, that was the headline figure, but the report goes on to question the sustainability of the actions taken to achieve that headline figure. It questions them in terms of sustainability and appropriateness, in relation to patient treatment and the cancellation of elective activity within the third quarter. It goes on to say that some of the measures taken are a poor way of addressing value for money. Are you satisfied that the approach taken by local health boards to achieve that headline figure was the right one?

[127] **Mark Drakeford:** I think that local health boards in Wales responded very positively and, in some cases, imaginatively to the obligation that they have to live within their means. I completely agree with Kirsty Williams that the Wales Audit Office report highlights a point that has been made regularly before now and that we are going to respond to, but there are some perverse decisions that any organisation will end up making when it has to bring a multibillion budget in right on the line every single year. That is why I am very grateful to my Cabinet colleagues and the First Minister, in particular, for agreeing to find space in the legislative programme for me to bring forward a Bill in the autumn that will amend the time frame in which LHB accounts have to be navigated in that way.

[128] Are there some difficult things that LHBs had to do? There certainly are. One-off savings happen every single year and there will be one-off savings this year, as there will be next year and the year after that. It is wrong to think that one-off savings are not a regular part of the way in which any organisation lives within its means. Of course, I am concerned about some of the ways in which the NHS was obliged to act in order to live within its budget and we will aim to provide it with a more flexible regime, which will help—it will not eliminate the challenge that the NHS faces, by any means, but it should allow a better quality of decision to be made in facing that challenge.

[129] **Kirsty Williams:** I will therefore turn to the detail of how LHBs performed against their own stated savings plans. The table that you have provided on page 52 of your briefing to the Assembly this morning demonstrates the savings that were outlined by the trusts themselves, what was actually achieved, and the percentage variants to their annual plans. In the case of Cwm Taf, there was a variation of 68%; in the case of Cardiff and Vale, it varied by 46%; and in the case of Nye Bevan, it varied by 31%. Given the inability of LHBs last year to deliver against their own stated plans, and that the savings this year are potentially even larger, could you give us an outline as to what measures you take to monitor against published savings plans, and what are the consequences? The previous Minister for health

was very strong on what the consequences would be if managers did not perform. What are the consequences for Cwm Taf and Cardiff and Vale, given that they have missed by such a significant percentage?

[130] **Mark Drakeford:** Perhaps I could make a start, Chair. With some of the more detailed, underlying aspects, I will ask my officials to fill in. There is a very rigorous, and increasingly rigorous, regime that is applied from the centre to local health boards to monitor their financial performance, as is referred to in the Wales Audit Office report. It is commended in the Wales Audit Office report, which says that we now have a monthly monitoring system that is reliable, detailed and provides us with information on which we can confidently assess the performance of local health boards on a monthly basis, and take action where we need to do that. In terms of what the consequences are for organisations that fail to live within their budgets, neither Cwm Taf nor Cardiff and Vale failed to live within their budgets. They both delivered balanced budgets. Indeed, Cwm Taf not only delivered a balanced budget, but it provided money to Powys Teaching Local Health Board that, outstandingly of all local health boards, did not manage to live within its budget. I think that that is the answer in those particular cases.

[131] More generally, however, my approach to the important question that Kirsty raised is that, where I am satisfied that local health boards—their senior managers and the boards that I appoint—are doing everything that you would expect them to do in order to manage the very challenging position that they face, I will act accordingly. If I believed that there was a board that was not facing its responsibilities, that was not taking actions that other boards in other parts of Wales were taking in order to meet their financial challenges, I would take a very different view. I do not take a sort of blunt ‘take ‘em out and shoot ‘em’ sort of approach to organisations in the position that Kirsty outlined, but that would not preclude me from taking action—and direct action—if I believed that a board’s failure was as a result of its failure to do all of the things that it ought to do and that other people are doing.

[132] **Kirsty Williams:** To come in on budget, however, the audit office’s report states that half of that was achieved by savings within the individual LHBs, and a significant proportion—29% of it—was because you actually had to bail them out and you gave them additional money on top of the initial resource allocation, and that other actions, including technical accounting adjustments, accounted for the rest. Are we absolutely clear here that what happened to deliver on budget was as a result of the actions taken by the LHBs, or is there actually not a more complete picture in the one that is presented, not in your report, but by the audit commission?

[133] **Mark Drakeford:** I completely agree that a more complex picture lies behind the figures. I am always a bit puzzled as to where the argument about extra help from the Welsh Government goes in this. Is it an argument that we should not have given extra help, and, in which case, some of the difficulties that local health boards face, and the actions that they would have had to take, would have been a good deal more drastic, with a greater impact on patient experience, or, is it as different sort of argument? My predecessor, quite rightly, found extra help for LHBs during the financial year. That has made a big difference to their ability to come in on budget—£25 million in the case of Cardiff, £10 million in the case of Cwm Taf. Without that extra assistance, their ability to come in on budget would not have been the same. The technical accounting adjustments are things that happen again every year. The audit report refers to them. It says that they have been given a clean bill of health, as were the individual accounts of LHBs when they were audited.

[134] **Leighton Andrews:** During the second Assembly, I was a member of the Audit Committee and I remember, even in the good times, some of the LHBs and trusts having difficulty coming in on budget. In respect of these figures, we know that a number of the health boards inherited deficits when they were created from predecessor bodies, including

trusts. First, are you satisfied that those inherited problems have now passed their way through the system? Secondly, are you satisfied, in terms of the development of budgets for the local health boards, that sufficient attention is given to issues such as inequalities in health?

[135] **Mark Drakeford:** On the first question, Leighton, I probably will ask Martin Sollis to help me with that. I think that the answer in broad terms is 'no'; those inheritance issues have not completely worked their way through the system. There is still some underlying debt that local health boards carry as an inheritance of their past.

[136] The second issue is of a different order. It is a very difficult issue. I am not going to pretend at all that it is not. I have asked the chief medical officer to lead a piece of work on updating the Townsend formula and to look at its application to budgets in the health service today. Just as you recalled the Audit Committee in the good days, I recall just how difficult it was to move to Townsend shares when we were doing it by differential distribution of growth. In those good days, no health board lost money; we just used the extra money and tried to slightly skew it in a way that would lead us to fair Townsend shares. That caused a huge furore in those places that felt that they were not getting the share that they would have got if we had not done that. Trying to reach Townsend shares in an era when there is not a differential distribution of growth, but a differential distribution of reductions in budgets, strikes me as an even bigger challenge. I do not think that that means that we should shy away from exposing what a fair share, matching spend to need, would look like in Wales. We do know that that would not look like the way that spending happens at the moment.

[137] **David Rees:** Lynne is next.

[138] **Lynne Neagle:** Yes—

[139] **Leighton Andrews:** Could I just get the answer on the first bit?

[140] **Mark Drakeford:** I am sorry. This is on inherited deficits. Martin, would you come in?

[141] **Mr Sollis:** I think that it is fair to say that every LHB is in a different position, which is why their plans are individual. They all have different histories in terms of their service configuration and the opportunities that they have to drive efficiencies, and they all have different backgrounds in terms of where they sit financially. I think that you have to look at each one in its own right. Do some of those opportunities and some of that history still exist in terms of underlying pressures and the way that those services are configured in certain areas? I would say, 'yes', but each one is in a slightly different position, depending on where they are historically and the way that services have grown up over that period.

[142] **Lynne Neagle:** I have two points on Townsend. You will remember, Mark, that I was a very enthusiastic supporter of Townsend and that I ended up being quite disappointed about the way that it all panned out. I very much welcome what you have just said and I would like to ask whether you could perhaps provide a note to the committee on how that process is going to work.

11.15 a.m.

[143] The other issue that I wanted to ask about is that I remember, when we were discussing the budget last year, we were all, in this committee, pondering whether we were going to see a lot of cancelled operations, et cetera, in the last quarter of the financial year. Indeed, the audit report has picked out that there was, what it calls, a 'significant drop in elective activity', which, it also says, cannot be fully explained by winter pressures, et cetera.

So, it does appear that there was a certain amount of that going on. I was wondering what work your department has done to quantify the extent to which that happened throughout Wales, because, clearly, it is an area that has a massive impact on patients.

[144] I also have a question on social services, but I will ask that later, Chair, if you prefer.

[145] **David Rees:** Yes, come back to that one.

[146] **Mark Drakeford:** We are very happy to provide a note on the work that has been done on the post-Townsend review. When I look back over my 10 years of working in the background of the Welsh Government, working with Peter Townsend is one of the things that really stands out in my memory as a fantastic thing to have been able to do.

[147] David will be able to give you some specific figures on this matter. It is a good point that you make because, although the audit report refers to some local evidence, as it says, of elective surgery being cancelled to save money, it never quantifies it—it does not say how many health boards had done it, as it just says ‘a number’; it does not tell us who they were or how many of them there were; and, it does not tell us how many operations were cancelled. I do not dispute, however, that, in the final run-up to the end of March, when they have to balance their books, organisations will have been making decisions about whether to go ahead with operations in March or in April. Where they did that, then it will have been done on the basis of clinical priority.

[148] My belief is that what really happened in the winter was not that people were cancelling operations in large volumes to save money, but that they were cancelling operations in significant volumes because beds were simply not available to carry out those operations. I have had to meet some very frustrated clinicians in hospitals in Wales who had lists that they wanted to operate on and were being told that they were not able to do that because the beds were full of people who had been admitted on an emergency basis. I think that that is what lies behind the fact that we did not manage to do what the Welsh health service has done for at least the last 10 years, which is to use the last quarter of the year to catch up on elective activity. I have tried to say to the health service—as I have tried in the past, but, clearly, with not that much success—that that cannot be the way that it does it. It needs to use this time of the year, when there is a little bit of a reduction in emergency pressures, to do elective work and to not try to get elective work done in large volumes just at the point of the year when emergency pressures are likely to be at their height. I think that David has specific figures that he could offer you.

[149] **Mr Sissling:** We have done quite a lot of analysis of this, quite understandably, because the commentary in the health finances report made us feel that we needed to get underneath it. The picture that is emerging is that there was a significant increase in demand for acute beds in winter, and that was particularly associated with emergencies, acutely ill patients, particularly the elderly, and with significantly increased lengths of stay. That, therefore, made the number of occupied bed days associated with that increase very significant. They were at unprecedented levels, with thousands of extra bed days.

[150] The health boards increased the number of beds in response, up to, at any point in time, about 300 beds across Wales. However, they were still in a position where the medical capacity was not sufficient to contain the medical demand. Therefore, patients, quite appropriately, had to be positioned in surgical beds on occasion, so that the service could respond to matters of clinical priority. That meant that the ability to undertake surgical activity was compromised. There were postponed elective operations and, over the last three months of last year, the number was in the order of 2,600. This was all down to bed availability and not to do with finance. The boards simply did not have the beds. However, they did carry out elective activity, but that was clinically prioritised. They undertook it in the

context of the clinical priorities—cancer patients and various patients who needed urgent surgical treatment. In some cases, the health boards spent money on additional activity, with waiting-list initiatives. Again, they did that to respond to clinical need. So, they spent additional money over and above. When they reached the point where they had to take decisions about whether they would then go, for example, to the independent sector and pay at excessive premium rates for activity, in some cases, they took a decision in the context of their statutory responsibilities. That is the picture that is emerging from our analysis. This was driven by unscheduled care, clinically driven decisions and the unavailability of beds in a very difficult situation that was recognised across the whole of the UK—every part of the UK experienced this, and the outcome was that there had to be some postponements of elective activity.

[151] **Lynne Neagle:** I hear what you are saying about that, but the report says clearly that NHS bodies had said that decisions were taken to reduce elective activity in non-priority areas, based on clinical need, in order to reduce costs. Have you done any work to find out which bodies they are and which operations were cancelled?

[152] **Mr Sissling:** I have written to the chief executive of every health board and asked them formally if they cancelled any elective activity for financial reasons, and they all said that they did not.

[153] **Lynne Neagle:** They did not?

[154] **Mr Sissling:** I will be asking the Wales Audit Office for the evidence, because I am interested in knowing where it observed this or where it found the data that allowed it to come to this conclusion.

[155] **Andrew R.T. Davies:** Can you give us a note on that evidence, when you have it, because there is quite a difference between what is in the audit office report and what they are telling you. So, when it supplies you with that information, is it possible for us to have an overview supplied to the committee?

[156] **David Rees:** Would you be happy to provide the committee with a response once you have your analysis?

[157] **Mr Sissling:** I would be happy to consolidate that.

[158] **David Rees:** I have one question on that. Minister, you mentioned bringing forward a three-year programme as a consequence, and this has highlighted the difficulties when coming towards the end of the financial year. Are you comfortable that the mechanisms that you have, particularly the monthly check-ins that you now have in place, will not allow that problem to escalate into a large problem at the end of the three years, which probably could not be sustained?

[159] **Mark Drakeford:** Thank you for that question, because it allows me to put on the record again that, every time that I think about this, I am absolutely determined that when we move to the new, more flexible regime, as proposed by the Public Accounts Committee and the Finance Committee—and which I think that everybody agrees has a lot of sense in it—it does not for a moment or in any way let health boards off the hook from meeting their financial responsibilities. It creates no new money by itself at all. It simply allows them to make better decisions about how they spend the money that they have. I am determined that we will put robust checks and balances into the way that we go on managing the system, so that nobody should be under any illusion at all that moving to a three-year regime means two years of partying followed by one year of a very bad headache. [*Laughter.*] It is not going to be like that.

[160] **David Rees:** Thank you, Minister. Gwyn has an extra question.

[161] **Gwyn R. Price:** You have stated an intention that the Bill will take effect in 2014-15. Given the amount of work that appears to be needed in relation to changes to financial planning and management within the health boards, how confident are you that they will be ready by that date?

[162] **Mark Drakeford:** It is my ambition to have it in place across Wales for the start of the next financial year, because if we think that more sensible decisions would be made if we had it, then the sooner that we get it into place, the sooner we will get the better decision making. In order to do that, we are moving our financial planning requirements forward. We are going to carry out a number of exercises in the autumn that, otherwise, we would have carried out after Christmas, in order to interrogate the balanced service plans that LHBs have to provide and will have to provide over the three-year horizon. However, I would like to say today that I am keen to make sure that we implement this in the best possible way. I will be writing to the health spokespeople of the three opposition parties, inviting them to meet with me in September before the Bill is published and while we are still in the process of developing its final detail, to discuss some of these issues about how we make sure and have a shared confidence that we can implement this new regime in a way that gives us the advantages of new flexibility, while not losing the rigour that we need in the management of finances. So, I repeat that it is my ambition to introduce it everywhere. I will not introduce it everywhere if I am not confident that individual LHBs have the plans in place that would give us all the confidence that they are going to be able to act responsibly and properly within the new regime. My ambition is that they are all able to do so, and that we will work with them over the autumn to ensure that that happens. However, I am very happy, if opposition party spokespeople are prepared to do so, to discuss some of this thinking in September, before we get to the point when the Bill is published.

[163] **David Rees:** I have one supplementary question from Kirsty on this, and I will then move on to William.

[164] **Kirsty Williams:** The audit office's report says that the NHS bodies did not have realistic savings plans in place for the year 2012-13. We know that there is already a shortfall between the savings identified for the forthcoming financial year. Minister, you have said that you are confident that by the autumn, these LHBs will have those plans in place. What enables you to say that, given what the audit office said about last year and given that we already know that there is a significant shortfall between what LHBs say that they can save and what they need to save?

[165] **Mark Drakeford:** I think that what the report says is that LHBs are over-optimistic at some points and over-pessimistic at others. At the beginning of the year, they were over-optimistic, and in the first six months of the year, they did not make the savings that they had predicted that they would. In the second half of the year, they were pessimistic and achieved more than their plans said that they would. When the audit office says that they are not realistic, it does not always simply mean that LHBs think that they are going to do better than they do—sometimes they do better than they think that they are going to do. The report says that it is about getting a proper balance between over-optimism and over-pessimism. What I meant to say, Chair, even if I did not quite say it in the right way, was that we need to be confident about this by the end of the autumn. If we go in, on a pan-Wales basis, to a three-year regime, we need to be confident that every board is in a position where it can take advantage of those new flexibilities properly.

[166] **William Graham:** I wish to ask about capital investment, if I may. I note that you say that a reduction is usual for capital programmes of this size and complexity and also what

you say about slippage; we accept that that is reasonable. However, it is a substantial reduction. Has it had a direct impact on your capital budget?

[167] **Mark Drakeford:** The capital budget has to be managed across the whole of the year. I think that it is important for me to make the point that we did not have an underspend in the capital budget last year, in the sense of sudden unexpected things emerging at the end of the year where we thought that money was being spent and it was not. The money that became available from the capital budget, which allowed us to make a contribution to the extra revenue that the previous Minister for health made available, was money that we knew about because of the month-by-month monitoring that was carried out. As a result, I think that we can be confident that there were not things that did not go ahead that were capable of going ahead because of the way that the capital budget was managed. In terms of the capital that we thought was going to be spent, and could be spent, it was spent within a very small—less than 1%—portion of the budget than was expected.

[168] **William Graham:** You also say that the five organisations in south Wales are currently undertaking their consultations, and that it would not be appropriate to pre-empt the outcomes of these—I see you nodding. Presumably, because you say that you are going ahead with working closely, the business case for the critical care centre at Llanfrechfa, for example—you might have imagined that I would ask you about that—will not be affected by this. The whole of your consultation is predicated on that. Option 3 is the one that you seem to want; it is all to do with this pressing ahead. All of us who have been here for the last 14 years have heard about this chimera. We very much hope that it is going to go ahead. Your capital budget is now critical to this; please reassure us.

[169] **David Rees:** To clarify, this is not what the Minister wants; option 3 is a proposal by the south Wales programme board.

[170] **Mark Drakeford:** Thank you very much; I was going to say exactly that. I do not have any views on the programme. However, the point that William Graham makes, which is absolutely fair, is that the specialist and critical care centre is in every option; therefore, you cannot imagine an outcome that does not have it as part of what is going ahead. In a moment, I will ask David Sissling to rehearse the correspondence that he had with the chief executive of Aneurin Bevan Local Health Board, giving the board answers to questions that it has raised about this. This is a continuing challenge, but it is very important for us to meet it, to shape our capital budgets for the future, and to meet the outcomes of reconfiguration. If we are going to be changing services, and if there is going to be a capital component to that, we have to use the declining capital resource that we have available ever more sharply to meet those needs. David may want to say something on this.

11.30 a.m.

[171] **Mr Sissling:** The correspondence was what might have been expected from Aneurin Bevan, asking for clarification. My response was that, first, there were matters of process—there was a business planning process that had not been concluded. As you would expect, with a project of this magnitude, that process has to be extremely rigorous in every regard. I also provided the information that this particular scheme is in our future capital programme. So, the quantum of finance is there. However, the movement from it being there, in terms of a planning exercise, to anything that releases from that, would be dependent on the outcome of the consultation and, moreover, the successful navigation of the business planning process.

[172] **William Graham:** Using the wonderful phrase ‘spade-ready’, if all of the consultation takes place, you will have the money in your budget without a particular problem. All of the questions on the business plan will be answered, and all that you want from the health board will be in place.

[173] **Mr Sissling:** As I said, the business planning process has not been concluded yet. That has some way to go. There is a lot of testing that will rightly have to be progressed, to a point where there is satisfaction that this is an appropriate point for investment. However, the point is that this is a line in the forward programme, so the financial quantum is recognising the forward programme.

[174] **William Graham:** I have another question, if I may ask it, Chair.

[175] **David Rees:** I have two supplementary questions on this particular point, and another from Elin on capital. We will have Kirsty first, then Lynne.

[176] **Kirsty Williams:** I am curious that the business case has not been fully completed; you have indicated that there is a lot more testing to go. Two years ago, the former Minister for health, Edwina Hart, said that she had given the go-ahead for the project. Could you explain to me why the former Minister said two years ago that the project had the go-ahead, but that you are now saying that the business case needs further work? What has happened in those two years?

[177] **David Sissling:** I could not comment on what happened two years ago. The business planning process is dependent on a business case that is subject to scrutiny. That is a laid-down process. We have to do it with anything of any scale, but particularly with something of this scale, we have to be extremely rigorous in the way that we do it. It is a laid-down process that we are now following, and we are subjecting that business case to appropriate scrutiny.

[178] **Lynne Neagle:** I have seen the health board letter, and I was very reassured by the reassurances that you gave the board that the money is in the capital programme. Could you confirm for the committee that the health board was satisfied with that letter and that it is now proceeding on that basis, to work up the proposals fully for the SCCC?

[179] **Mr Sissling:** The health board was very reassured and satisfied, and it is now working with the guidance that we put in the letter about the way that the business case could best be progressed.

[180] **David Rees:** Is this a new business case, or is it the original business case?

[181] **Mr Sissling:** I am not sure that I can—

[182] **Mr Sollis:** I believe that the service requirements, as a result of the consultation, have changed. There is a change in the service provision. There is a reflection of the more up-to-date costs in relation to doing that. So, the principles are the same, but the requirements have changed.

[183] **Kirsty Williams:** [*Inaudible.*] That is curious because we were told that we do not need to have another consultation, because exactly the same services were consulted on five years ago.

[184] **Mr Sollis:** The principles of the services are the same. This is about the cost quantum, the timing and the detail in the business case.

[185] **David Rees:** That is okay. That point needed to be clarified.

[186] **Elin Jones:** I want to back to William Graham's original question around the magnitude of the transfer from the capital budget to the revenue budget. It was £42 million last year, out of a budget of £244 million. A significant proportion of the budget was not spent

on capital investment, and we know how important public sector capital investment is to the wider economy. I want to ask you, in terms of this year's budget, and you will know what is being built and not built at this point—or you should know—how confident are you that that magnitude of transfer, of around 20%, will not be happening again this year?

[187] **Mark Drakeford:** Well, I have seen no advice to me to date that suggests that we will be making a transfer out of our capital budget for revenue purposes this year.

[188] **David Rees:** Lynne has the next question.

[189] **Lynne Neagle:** I have some questions about the social services budget. Deputy Minister, your paper states that, as we know, protection was provided for social services budgets across Wales. You say that, overall, the evidence shows that local authorities are delivering on this, but at an individual level the picture is more varied. Can you give us some more detail on what exactly that means, please?

[190] **Gwenda Thomas:** Yes. You will know the background to this. From 2011-12 to 2013-14, this additional money—£34 million a year—was provided to local authorities. That meant a protection of 1%. I have been advised this week that all local authorities have exceeded that amount. It would mean a 3.3% increase in their budgets to comply with what was required of them. You know that local authority budgets are not hypothecated, but there are ways that you can say you are making money available for specific purposes. I am glad to say that the Minister for local government has received a response from all 22 local authorities in response to a request from her for them to say how this has been used, and every local authority in Wales has exceeded 3.3%. That is not to say that everyone has done it every year, but, over the three-year period, all local authorities have. The figures that I have show that the lowest expenditure was by Denbighshire at 4%, the largest was by Pembrokeshire at 25%, and the average net expenditure increase was 13%. So, local authorities have delivered and exceeded what was expected on that.

[191] **Lynne Neagle:** I wonder whether maybe that information could be shared with the committee, as protection for social services is an issue that comes up regularly. Going forward, after this year, the protection will not be there. That is very worrying, because I know that, in Torfaen, the council has forecast that if it is going to protect social services and education, which I very much support, then it is looking at finding some £40 million in savings across all other budgets, which is clearly going to be extremely challenging without taking money out of the social services budget. So, I wondered what discussions you are having with local government about how that protection is going to be maintained without the extra resources going in from the Welsh Government.

[192] **Gwenda Thomas:** In those responses I mentioned, local authorities make the point that they are facing extremely difficult budget negotiations. Those negotiations are going on both with the Minister for Finance and the Minister for local government, but it has always been absolutely clear that that protection was for a limited period. We know that that is going to be difficult, but I would like to say that we are also pressing the case for transformation. You will know that local authorities have an implementation plan for sustainable social services and are beginning to deliver. This is a real point in question: we have to work in different ways and we have to have more collaboration. As I said, we are in the midst of budget negotiations and I am not able to say any more than that on that issue at the moment.

[193] **Lynne Neagle:** This is a very important issue. I know that, before the protection was put in place, councils were regularly raiding social services budgets for very significant sums. Will you be able to keep the committee updated on that? What monitoring will you undertake now? I think that there is a very real danger that, without some guidance and a clear steer from the Welsh Government, we could see all sorts of money being taken from social

services, which would, in turn, undermine the health service.

[194] **Gwenda Thomas:** Yes, indeed. Through the partnership forum that I chair—you know about the partnership forum—this point is being raised. Indeed, it is being raised at every opportunity. I do not blame local authorities for that. The Welsh Government is also facing stringent requirements on the budget, but I am listening to local authorities. I meet them regularly and I am meeting the Minister for Finance later today.

[195] **David Rees:** Rebecca is next, then Lindsay.

[196] **Rebecca Evans:** My questions are to the Deputy Minister on the £50-a-week cap on domiciliary care charges. Initially, when the cap came in, the aim was that nobody was going to be worse off as a result of the cap. At the time, some local authorities were charging well below £50 a week. How many local authorities are now charging the full £50 a week? How many local authorities have raised their prices to £50 a week, which was only ever supposed to be a maximum and not a standard charge?

[197] **Gwenda Thomas:** I do not have that figure with me. The last advice that I had on that was that it was very few that were not charging £50—I think it was one authority. I will write to the committee on that, to be clear about the position, but the majority of local authorities are charging the £50 limit now. All of them are now.

[198] **Rebecca Evans:** Originally, local authorities estimated that the cost of the policy would be £10.1 million, but they have recently reviewed that and said that the cost is £15.9 million. You have announced £3.2 million funding to close that gap, but there still remains a further £2.6 million. Where would local authorities be expected to get that from in difficult financial times?

[199] **Gwenda Thomas:** I think that the £3.2 million is a fair settlement with regard to the gap. The £10.1 million was the estimate of local authorities themselves and we know that that rose to £15.9 million after the monitoring process. The gap of £2.6 million cannot be put down to the £50 cap alone. There were authorities that did not have upper charging limits and those are the authorities that saw the greatest effects on their revenue from the charging policy. So, I think that it is fair to have made this money available. This money will now be added to the revenue support grant.

[200] **Rebecca Evans:** I have one last question on this. Since the policy came into place, an extra 8,000 people are receiving services for the first time. Do you expect this trend of increasing numbers to continue? If so, what plans do you have to address it financially?

[201] **Gwenda Thomas:** I do not think that that rise is going to continue because of the £50 cap. There was an increase; of the 31,000-odd people using the service in 2011-12, 7,858 were receiving services for the first time. We think that that has levelled out now, but that is not to say that there will not be extra people needing services, because of demographic changes and other issues. However, on the charging policy, we think that it has levelled out at that level. If there had not been extra people coming forward, then I do not think that I would have felt that the policy was achieving what we intended it to achieve, because most of those people would have been paying privately for care, or doing without care. That is my impression of why there was that rise.

11.45 a.m.

[202] **Lindsay Whittle:** I do not share your confidence, with respect, about the figure levelling out. I fear that the situation will get worse as the population, thankfully, lives longer. I am sure that you agree with me—I know you will—that, if it was not for the army of

volunteers, good neighbours, carers and families, we would be in a much bigger crisis in social services. I will refer back a little bit to what Lynne Neagle said about local authorities and where they would get the money from. We know that local authorities—and you mentioned it in your evidence—are continually having to fund social services from reserves. Perhaps most of them do so. However, they have a district auditor breathing down their necks to say that they must keep so much in reserves. Then the media will criticise local authorities for keeping millions in reserves, but, if they did not keep those millions in reserves, social services would suffer: there is no doubt about that. You said, Deputy Minister, in your evidence to us that you will be looking at revising the maximum level of charge in 2014. Can you give us an indication of what figure you are looking at, or is it too early?

[203] **Gwenda Thomas:** I am thinking of a straightforward rise for 2014, based on things like inflation and levels of benefit, for example, but I cannot be more explicit than that about the level of rise in 2014. However, for 2015, I would like to use the year to look in detail at the impact of the policy, how it has benefited people, and how we should look at that level from 2015. That needs consultation with stakeholders, local government and service users so that we get to a realistic point by the financial year beginning in 2015.

[204] **Lindsay Whittle:** Thank you for your reply, Deputy Minister. Would it be fair to the stakeholders and the people whom we are all trying to serve, if, by 2014-15, you were able to give them a three-year figure so that local government could plan its finances as well?

[205] **Gwenda Thomas:** I hope to do that as soon as possible, and I am talking to it now.

[206] **Lindsay Whittle:** Okay, thank you very much.

[207] **David Rees:** The next questions are from Andrew and Elin.

[208] **Andrew R.T. Davies:** Minister, you, along with the Minister for Finance, announced a review of the NHS budget last week, which is something that I welcome. Politically, obviously, we have had our ding-dongs in the Chamber about how much is going into the NHS budget. The First Minister, in his press conference on Monday, said that the Welsh Government would make adequate provision for the NHS in the future. What would you say is adequate provision for the NHS?

[209] **Mark Drakeford:** I am not in any way able to answer that by offering a figure. What I can do is to say to the Member that what we will be doing over the summer is, working very closely with the Minister for Finance, looking at what the Francis review tells us about the nature of demand in the NHS, the new burdens that the NHS is having to carry that have a financial consequence, and, in terms of the biggest driver of all for money, the staffing implications that the report drives out. By the autumn, we will have a much better idea of whether the current budget allows the NHS to be Francis-compliant or whether any changes will need to be made. Those figures will be available then and will in some ways answer the question that I have been asked.

[210] **Andrew R.T. Davies:** Is it fair to say—given that the First Minister has acknowledged that maybe not enough money has gone into the NHS historically—that, going forward, the mantra of the Welsh Government will be to fund the NHS in Wales adequately and therefore that we will be expecting to see an uplift in the resource that goes into the NHS to carry out what the First Minister said about providing adequate funding for the NHS?

[211] **Mark Drakeford:** The NHS in Wales lived within its means last year. Most of us believe that, if we have £100 to live on, and we manage to live on £100, our means have been adequate to our needs. So, I do not accept the basic premise of the question. What we will know, by the end of the exercise that we are engaged in, is whether the budget is sufficient to

meet the new cost pressures in the new circumstances that we face. That is what I am going to be working on over the summer.

[212] **Andrew R.T. Davies:** Could I take you along the road, then, given that we will not come up with a figure today, and I appreciate why that is the case? There has been change in senior personnel at the head of various LHBs. The crux of the report that looked at Betsi Cadwaladr LHB, for example, pointed to the breakdown in the relationship between the executive and the non-executive. If I come to the south, in Cardiff and Vale health board, for example, there has been a significant turnover of chairmen and chief executives in the time that I have been an Assembly Member. When you look at the executive structures in our health boards—and those are the two biggest that I have offered you as an example—are you confident that the executive structures and the executives who fill those positions are able to meet the demands of the NHS in the twenty-first century and, in particular, the demands that you as a Government place on them, given the damning report into Betsi Cadwaladr and the high turnover that I pointed to in Cardiff and Vale?

[213] **David Rees:** I am not sure whether that is a financial question, but if you wish to answer it, Minister, you may do so.

[214] **Mark Drakeford:** I will answer it in this way because I think that the question very fairly points to the fact that these are hugely challenging jobs, and we expect a very great deal of the people who we appoint to do them, and that there is some evidence—we discussed it on the floor of the Chamber yesterday at a much lower level, you might say, in the struggle that we have to fill CHC vacancies—that, as these jobs become ones that get you regularly onto the front of newspapers and before Assembly committees and so on, there is a danger, and it does worry me, that we will end up with good people not being willing to do some of these jobs and to put themselves in the firing line, as they sometimes put it to me. I am very keen that we grow a new cadre of leaders inside the Welsh NHS for the future, and I think of that at both the executive level and the clinical level. Andrew, one of the other big jobs that we do not always find it that easy to fill are medical director posts in LHBs, because there is a bit of a sense of, ‘Who would willingly do them?’ I do not think that we have got to that stage at all; when we advertise these jobs, we still get very powerful fields. We get strong people willing to do them, and the jobs are doable. We have good evidence of where they are doable. However, I think that the challenge that you point to is a very real one. In a way, we all need to think about how we grow the next generation of leaders—clinical and executive leaders—and allow them to do the job that we want them to do, without them feeling that the scrutiny that they are under is not simply fair and open scrutiny, and all the things that we need it to be, but scrutiny in which everyone appears to be looking for reasons why they failed. I do not think that that happens here. It certainly has not happened around this table this morning, but I think that, out there, for the people doing the jobs, it can sometimes feel like that—that all that anyone is interested in is finding things that you have not done well, and that people very rarely focus on the many good things that go on in Betsi Cadwaladr, for example, as well as anywhere else. It is a big-picture question.

[215] **Andrew R.T. Davies:** May I just make a point about non-executives, Chair?

[216] **David Rees:** That is fine.

[217] **Andrew R.T. Davies:** The executive, obviously, is very important, but non-executive supervision is vital to a successful organisation. The failures and successes are attributable in both positions, and I think that maybe the Welsh Government needs to focus on that.

[218] **Mark Drakeford:** The WAO and HIW report on Betsi Cadwaladr, I think, exposes exactly that issue very directly.

[219] **David Rees:** Leighton has a supplementary question.

[220] **Leighton Andrews:** It is a question on this, but it is—*[Inaudible.]*—relationship between the non-executive and the executive. Do you think that there are any structural challenges in respect of how that relationship works, given the reporting into the service of the executives, which may have a slightly different relationship from, say, the reporting in of the non-executive chair?

[221] **Mark Drakeford:** Yes; I think that there are some structural issues that we should think about, in the ways that boards themselves conduct their business. I think that the extent to which boards understand the job that they are there to do, and the extent to which non-executives understand the job that we ask them to do, is a bit variable. We have some very good examples. It is why I have asked David Jenkins, for example, to go to spend some time in north Wales, because I think that his organisation is one where the board is very clear about the job that it is asked to do and how it secures the service that it needs from its executives to allow it to discharge its responsibilities. Does every board in Wales have the same security of understanding and the same systems to support them? Clearly not, from the report that we have seen. So, there are some structural things there.

[222] In terms of the relationship between the boards and the centre, we try a mirror image of these things—chief executives meet with the chief executive of the NHS, and I meet the chairs of organisations on a sort of parallel track, to try to make sure that people on the non-executive side of the system have an equally powerful path that they can use, if there are things that they think they need to make sure that I know about and can assist them in discharging the things that we ask them to do.

[223] **Leighton Andrews:** Do you think that, given the dual reporting lines, in a sense, it can create tension at a local level, possibly?

[224] **Mark Drakeford:** Yes. Sometimes, it is not unhealthy tension. I sometimes worry more that executives and non-executives do not have enough grit in the machine to make sure that non-executives do not regard themselves simply as the executive's friend. They need to be a critical friend—you know, they need to be a friend, but I worry slightly more that it is grit that we lack, rather than an inability to exercise that.

[225] **Elin Jones:** If I can go back to the capital programme, I just want to ask you something on that. Minister, you have said that you are working with the Minister for Finance on alternative sources of funding for the capital programme, and perhaps you could elaborate on your discussions and your thinking around that. Could you provide any estimates for us as to the amount of funding from alternative sources that will be necessary to fund the projects that you have in your capital investment programme? We think of the critical care centre in Gwent, which we have discussed, and, at a rough guess, that is about twice the size of your current annual capital programme. So, the question is one of estimates of how much funding from alternative sources you will require.

[226] Very quickly, you have provided us with information and numbers on cross-border hospital admissions, and there is an increasing trend of Welsh patients admitted to hospitals in England, and then a decreasing trend of English residents admitted to hospitals in Wales over the last five years. I was wondering whether you could offer any kind of explanation as to why those trends seem to be going in different directions.

[227] **Mark Drakeford:** On the first question, the current capital programme does not rely, for its implementation, on new and innovative forms of funding. However, I am pursuing some of those ideas with the Minister for Finance. They are at a relatively preliminary stage, so I do not have figures for them, but they are, for example, in the field of the primary care

estate. You know that I have announced a short moratorium on the primary care capital, which has caused a lot more of a furore than the impact of it requires. Part of that is because I have not been convinced that the model that we have used up to now is one that is fit for the future, and there may be some innovative ways that Gerry Holtham, for example, in his role of advising the Welsh Government, has been developing that we may be able to bring to the table to allow us to do the financing of some capital works in the primary care estate in a different way in the future. However, the capital plans that you see are not contingent upon having different ways of financing them in the future.

[228] There are flows across the border. About 50,000 procedures happened for Welsh patients in the English NHS last year. They cost just under £230 million. They happen, as you would expect, because we have a very porous border that makes that inevitable. Why we have slightly more flowing one way and slightly fewer flowing the other is not something that I have seen any analysis of particularly. There may be no deeper explanation for it other than the way in which GPs direct patients and the differing demographic that there is on either side of the border, because we do have a more elderly population, with a higher still group of people in the very elderly population, and that may be playing some part in that, too.

[229] **David Rees:** May I ask a question before I call the last question from William? On this cross-border issue, do the NHS boards actually report charges and figures for cross-border services, particularly those between England and Wales, but also between LHBs in Wales? We do not seem to see those figures easily. I have had my researcher looking, and it is very difficult to see some of them.

12.00 p.m.

[230] **Mark Drakeford:** We clearly have figures for what it costs us to have Welsh patients treated in the English NHS and, as I said, last year, something like £228 million was spent in that way. I think that, in the paper that was supplied to the committee, you will see that there is work going on to update the way in which financial flows are managed between LHBs, where a patient from ABMU is treated in Hywel Dda, for example. What we have had in the past is, pretty much, a historical roll-over of recharging between organisations. As services are reconfigured—think of it in the south Wales programme, for example—then there will be some additional cross-border flows of patients. I am advised that we need to update the way in which our system tracks those costs and apports them between the LHBs and that that work is going on at the moment.

[231] **David Rees:** The south Wales programme was something that came into my mind, particularly around the changes and maybe the Townsend calculation—

[232] **Mark Drakeford:** It draws that issue to the surface.

[233] **David Rees:** I ask for the last question from William.

[234] **William Graham:** On the good news on the health technology fund, Minister, I welcome the fact that we will have your announcement by the end of this month. May I ask that you particularly look at the provision of IT equipment? Each time that we have a presentation from consultants we ask them, 'If you were the Minister for health, what would you really want?', and their answer always is, 'More IT equipment'. They want it to analyse the accident figures and data that they have, which should lead to better clinical priorities in terms of diagnosis and treatment. Without pre-empting your announcement, does that find favour with you?

[235] **Mark Drakeford:** The basic proposition does. I am yet to receive advice on what those allocations might be, but I am looking forward to receiving that. I welcome very much

your kind words about the scheme, which is very much a cross-party initiative. IT is part of that fund, where it is genuinely innovative and additional. If there are schemes that come forward in that way, I am sure that I will get advice to that effect.

[236] **David Rees:** Thank you very much, Minister and Deputy Minister, for your attendance this morning and for giving us the answers. I also thank your officials for joining us, Martin and David, and also Ruth and Albert, who have already left. You will be given a copy of the transcript for the correction of factual inaccuracies. If there are any issues that you wish to raise, you may do so. We have several points on the list for you to write to us about. I am sure that you have a list of those, but if not, we can give you a copy. Thank you very much.

12.03 p.m.

Papurau i'w Nodi Papers to Note

[237] **David Rees:** Is everyone happy to note and agree the minutes for 10 July? I see that you are.

Cynnig o dan Reol Sefydlog Rhif 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod Motion under Standing Order No. 17.42 to Resolve to Exclude the Public from the Meeting

[238] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(vi).

[239] Are all Members content? I see that you are.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 12.03 p.m.
The public part of the meeting ended at 12.03 p.m.*

End note:

Local medical committees are statutory bodies in the UK under Section 53 of the NHS (Wales) Act 2006. They are recognised as the professional organisation representing individual GPs and GP practices as a whole to the primary care organisation.

There is a requirement on health boards to consult with LMCs on matters relating to GPs and general practice.

While the British Medical Association and the General Practitioners Committee work closely with LMCs, they are not a branch of the BMA and neither do they represent the BMA or speak on behalf of the BMA or the GPC.