Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Iau, 17 Hydref 2013
Thursday, 17 October 2013

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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
Rebecca Evans	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
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

Nicola Amery	Cadeirydd Cymdeithas Gofal Iechyd Annibynnol Cymru, Rheolwr Ysbyty Spire Caerdydd Chair of Welsh Independent Healthcare Association, Hospital Manager, Cardiff Spire Hospital
Steve Bartley	Cyn-ddirprwy Gadeirydd Cymdeithas Gofal Iechyd Annibynnol Cymru; Unigolyn Cyfrifol, Ludlow Street Healthcare Immediate past Deputy Chair of Welsh Independent Healthcare Association; Responsible Individual, Ludlow Street Healthcare

Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Minister for Health and Social Services)
Dr Andrew Goodall	Prif Weithredwr Bwrdd Iechyd Prifysgol Aneurin Bevan Chief Executive of Aneurin Bevan University Health Board
Albert Heaney	Cyfarwyddwr Gwasnaethau Cymdeithasol, Llywodraeth Cymru Director of Social Services, Welsh Government
Karen Healey	Cadeirydd y Grŵp Uwch-nyrsys, Cyfarwyddwr Nyrsio Vale Healthcare Chair of the Senior Nurse Group, Director of Nursing Vale Healthcare
Katherine Murphy	Cymdeithas y Cleifion Patients Association
Cathy O'Sullivan	Cyfarwyddwr Dros Dro, Bwrdd Cynghorau Iechyd Cymuned Cymru Acting Director, Board of Community Health Councils
Imelda Richardson	Prif Arolygydd, Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru Chief Inspector, Care and Social Services Inspectorate Wales
Carol Shillabeer	Cyfarwyddwr Nyrsio Bwrdd Iechyd Lleol Addysgu Powys Nurse Director of Powys Teaching Local Health Board
David Sissling	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director General, Health and Social Services, Welsh Government
Martin Sollis	Cyfarwyddwr Cyllid, Llywodraeth Cymru Director of Finance, Welsh Government
Dave Thomas	Cyfarwyddwr Iechyd a Gofal Cymdeithasol, Swyddfa Archwilio Cymru Director Health and Social Care, Wales Audit Office
Gwenda Thomas	Aelod Cynulliad, Llafur (y Dirprwy Weinidog Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Deputy Minister for Social Services)
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

Sarah Hatherley	Y Gwasanaeth Ymchwil Research Service
Richard Johnson	Dirprwy Glerc Deputy Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk

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

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome Members to this morning's meeting of the Health and Social Care Committee. The meeting is bilingual and headphones can be used for simultaneous translation from Welsh to English on channel 1, or for amplification on channel 0. I remind everyone to turn off their mobile phones or other electronic equipment that may interfere with the broadcasting equipment. In the event of a fire alarm, as there is no scheduled fire drill, please follow the ushers. We have not received any apologies this morning, so I am sure that Kirsty and Darren will be attending shortly.

09:16

Ymchwiliad i Waith Arolygiaeth Gofal Iechyd Cymru: Panel 1—AGGCC a Swyddfa Archwilio Cymru
Inquiry into the Work of Healthcare Inspectorate Wales: Panel 1—CSSIW and Wales Audit Office

[2] **David Rees:** This morning's session is the first of two for the inquiry we are holding into Healthcare Inspectorate Wales. I welcome our first witnesses this morning. With us, we have Imelda Richardson, the chief executive of the Care and Social Services Inspectorate Wales, Huw Vaughan Thomas from the Wales Audit Office, and Dave Thomas, who is also from the Wales Audit Office. Welcome and thank you for attending. I also thank you for your written submissions, which are very much appreciated. To start off, could you give a very brief introduction to your work and relationship with Healthcare Inspectorate Wales, and we will then move to questions from Members?

[3] **Mr H. Thomas:** Chair, may I first of all say that, as you know, I am dependent on the loop system and I am hearing very clearly the committee proceedings from next door, or wherever. I will struggle to cope and hear, but please bear that in mind when you ask questions.

[4] **David Rees:** We will adjourn for five minutes to see whether we can resolve that.

[5] **Mr H. Thomas:** I would be very grateful.

Gorhiriwyd y cyfarfod rhwng 09:17 a 09:22.
The meeting adjourned between 09:17 and 09:22.

[6] **David Rees:** Welcome back. We are still trying to resolve some of the technical problems, but we will move ahead if that is okay.

[7] You were given the opportunity to explain your working relationship with HIW, and then we will go to questions from Members.

[8] **Mr H. Thomas:** To go back to when I took over as auditor general, I took over against a backcloth of having experienced several inspectorates dealing with me. I wanted to try to build a clear relationship with the individual inspectorates. As regards Healthcare Inspectorate Wales, we developed, as we have recorded, a particular concordat to make sure that we are sharing in terms of the forward work programme, and that we are trying to co-ordinate as best we can in terms of the delivery of our work. The recent study on Betsi Cadwaladr is an example of that. It is the case that Healthcare Inspectorate Wales works with us and we work with it in trying to understand the issues facing individual health boards. Clearly, its remit is much wider than that.

[9] **Ms Richardson:** In CSSIW, we work together as chief inspectors and chief executive on a bilateral basis. We meet regularly to discuss the joint inspection programme as well as the individual inspection programmes. The key pieces of work have been through the work we have done together, such as the inspection Wales programme. In particular, we have done joint work with HIW on safeguarding for adults and children. We have done joint inspections and joint inspection reports. For the last two years, we have also worked together to produce joint reports about the deprivation of liberty of older people under the Mental Capacity Act 2005. That has been very important.

[10] It is a statutory responsibility, but the joint report shows a willingness to not just work together, but to see that as another element of safeguarding. So, I think that those are the two key parts. We work together in terms of attendance at the health summits and on any matters arising out of left-field; we had a joint inspection with HIW as part of our Pembrokeshire work on safeguarding, and for the work coming out of the Winterbourne View report. The owners of Winterbourne View also had a number of registered settings in Wales, some of which were care homes, and the majority of which were small hospitals. We did joint work on that and wrote joint reports. All of those were positive, by the way.

[11] **David Rees:** Thank you very much for that. We have the first question from Gwyn Price.

[12] **Gwyn R. Price:** Good morning. Do you have a view on whether it would be better, in terms of patient safety, quality and value for money, to rationalise some of HIW's functions, or to increase the resources to HIW?

[13] **Mr H. Thomas:** It is the case that HIW is carrying out within Wales functions that are spread over a range of different bodies in England. I am concerned in terms of the totality of this work and what it means in terms of its resources. I suppose that I am concerned because the area that tends to suffer is that of studies. They are clearly giving priority in terms of some of their regulatory inspections, but we would like to ensure that we are able to do relevant studies. If we know that HIW is planning to do one, then we will not. However, on the other hand, if it is not going to do it, sometimes we think that the issue is important so we would want to do it. So, it is the impact of its limited resources that worries me.

[14] HIW has suffered particularly from being part of the Welsh Government's reduction of staffing. The Welsh Government, if you recall a couple of years back, shed a lot of staff in terms of voluntary early severance. It did it, as I have commented before, in not a planned manner, with the result that HIW lost a lot of key staff, which it has recovered now in terms of recruitment. However, it clearly hit its resources and had a particular impact on its ability to carry out studies.

[15] **Ms Richardson:** I would agree with Huw that it is about capacity and expertise leading to problems with capability. However, I also think that there needs to be some real focus now on the strategic plan for regulation and inspection of health and social care in Wales in terms of the kind of regulation you want and how it is going to be carried out. We do a lot of work in terms of adult care homes with nursing, and we would like to have a much closer working relationship around that, particularly on the commissioning of those nursing beds, because many of the come from health boards as well as from local authorities. We need to see some ability within the other inspectorates to focus on the near future as well as the here and now, because those are very expensive pieces of work.

[16] **David Rees:** Is it your view that there are some capacity resource issues as regards being able to do that?

[17] **Mr D. Thomas:** Huw and Imelda have already raised the capacity issue. There is a question of rationalisation as well. One of the issues to be looked at is the rather eclectic mix of the regulation side of HIW's work. Huw has indicated that that is skewing its capacity more to that side of its work, and leaving less capacity for the more quality and safety-driven inspection work, which, in the current climate of post-Francis, is hugely important. So, it is timely to ask, 'What is the scrutiny function of HIW and, therefore, what size and shape should it be to deliver that function?'

[18] **David Rees:** Gwyn, do you have anything else on that? I see that you do not, so we will turn to William.

[19] **William Graham:** Thank you, Chair. My first question is to the chief inspector of CSSIW regarding unannounced spot checks. Could you share with the committee how these occur, and whether you have a method of planning those? Could you just tell us what happens, please?

09:30

[20] **Ms Richardson:** In CSSIW, we have statutory responsibilities for a number of registered settings that need to be inspected every year. We have a risk-assessment process, which includes all the concerns that we receive—from members of the public, from families, from staff, from our previous inspections, as well as any comments from other inspectorates, such as local authority commissioners, and so on. Therefore, we risk assess, and we determine what our running order is going to be for the year. Every provider is required to produce a self-assessment statement and a quality review statement annually, so those are also analysed within the risk basis, and then we set out our inspection programme. All of the inspections are unannounced, so that no-one is waiting for the inspectorate, thinking, 'It must be about now; is that their car?'.

[21] We have a new inspection regime, in the sense that we now focus absolutely on the experiences and the outcomes of the people who need and receive the service, and on the views of the staff who do the work. We do two sorts of inspections. First, we do a baseline inspection, which is when we look at all four inspection themes, namely the quality of life, the quality of staffing and management, the quality of leadership, and the quality of the environment. Thereafter, if they get a good read-across on all of those issues, we may, the next time we do the inspection, do a more focused inspection, or we may do a focused inspection as and when other issues come up, when we will go straight out. Therefore, we do unannounced inspections, as a focused or a baseline inspection, but we also do additional inspections as soon as there are concerns. Therefore, in the last three years, we started off with doing 100% of our inspections, and that has gone up to 105% now, because we do so many repeat inspections. If we are going to one particular setting more than five times in a year, then, obviously, we are getting into the area of enforcement.

[22] **William Graham:** Thank you for that. Could I ask you then, if and when your inspectors are suspicious of a particular problem, or you identify a particular problem, in your experience, if it is sufficiently serious, how quickly is it corrected?

[23] **Ms Richardson:** We have a serious concerns protocol and, obviously, we make sure that the providers and the commissioners know about that. We have a graded range of opportunities, so to speak, from improvement to enforcement. The first is to make conditions, such as a condition to improve certain areas of the work within a number of weeks; we will go back to check that, and, if those are not done, then we will escalate into the next part of the process. The next part of the process is around those serious concerns. We have had a number of enforcement actions. In the last four years, we have taken on enforcement action in relation to 10 care homes with nursing, and nine care homes with personal care—sorry, that is in the

last two years. We have prosecuted some of those, and some have actually improved. Therefore, of the 19, five have closed—one of which was a voluntary closure; six out of the 19 were compliant, so they improved; three of the 19 went to representation, and we did not win the case, so we continue to monitor them; and four of the 19 are ongoing. To get to prosecution depends on whether we are going through a civil route or a criminal route, in terms of timing.

[24] **William Graham:** You identify the HIW plan to develop a number of service specific modules and you comment that

[25] 'limited progress has been made with this work'.

[26] What are your comments on that?

[27] **Mr D. Thomas:** This relates to the healthcare standards piece of work. HIW had correctly decided to move away from a heavy validation-based process of all of the standards to developing modules that support self-assessments by the health bodies. I think that that is widely perceived as a good thing to do; it encourages health bodies to build that into their everyday working. However, there still needs to be some validation. So, there are two things that we have to say about that. First, some of the self-assessment module work that HIW said that it was going to do has not, perhaps, been done within the timescale that it said that it would do it—it is a little slower than it said that it would be—which links back to capacity, as we probably said earlier. The second thing is the clarity about how that would work. So, if HIW gives a service a module against which to self-assess itself, what external validation would be done to ensure that that self-assessment was robust and to give assurance that the health body had done a full, thorough and robust job? I think that we are still waiting to see whether that will work in practice. So, it is still to be seen.

[28] **William Graham:** Finally, if I may, what is the timescale for that?

[29] **Mr D. Thomas:** That is a question for HIW. We do not know. We expected to see that by now.

[30] **William Graham:** Okay. So, that is a question for HIW—the timescale for implementation.

[31] **Ms Richardson:** I am afraid that I cannot answer that either. I am CSSIW.

[32] **William Graham:** I am sorry; yes, of course.

[33] **David Rees:** Rebecca, did you want to ask a supplementary question?

[34] **Rebecca Evans:** Yes, I have just one question. I want to take you back to the unannounced spot checks. In responding to our written consultation, we have had evidence that front-line staff are made aware of when unannounced spot checks are going to take place—

[35] **Ms Richardson:** I am sorry; is this for CSSIW?

[36] **Rebecca Evans:** If you bear with me; I will check.

[37] **David Rees:** It is for HIW.

[38] **Ms Richardson:** The Care and Social Services Inspectorate Wales is my organisation for social care. We absolutely do unannounced inspections, not spot checks. I cannot answer

for HIW and its spot check system.

[39] **Rebecca Evans:** Right, okay. I am sorry; I got over-excited with the spot checks question. I will save it for later.

[40] **David Rees:** May I ask about these unannounced inspections? You mentioned that some of those 19 inspections involved care homes and nursing. Was HIW involved in those?

[41] **Ms Richardson:** It was not involved, because, while we have multidisciplinary teams, my inspectors also include registered nurses who are used to inspecting and evaluating nursing care. However, we obviously share the information in terms of saying, 'These are the problems …' We would share that information with the local authority and the health board, because they would be commissioning within those settings and it might be that the local authority would also be taking actions to protect vulnerable people through safeguarding routes. So, it becomes a much bigger piece of work than just us determining that things are not working; we share it systemically.

[42] **David Rees:** Lindsay, do you have a question?

[43] **Lindsay Whittle:** Healthcare Inspectorate Wales has the ability to place NHS bodies under special measures—very drastic measures—but it cannot do so without the permission of the Minister. You mention in your report to us that you believe that those arrangements merit a review. How would we review that? Would the Minister review it? Would this committee review it? What is the process for that review and what would you recommend happens?

[44] **Mr H. Thomas:** We have raised that issue, particularly with the Public Accounts Committee, in the context of the Betsi Cadwaladr report that we issued recently. We were concerned about two things. The first was that there was not an understood escalation process within the Welsh Government and the second was the extent of the input of special measures and what it meant. We are now working, as a result, with the Welsh Government and HIW to develop a protocol on that and I would hope that within a matter of a couple of months, we will be in a position to come back with a much clearer understanding. If you use phrases such as 'special measures', it needs to be understood: what exactly is the first level of a special measure and so on.

[45] **Lindsay Whittle:** I assume that it is not simply about pouring more money into something; it is about ensuring that systems and the whole delivery of a service are better understood by the professionals.

[46] **Mr H. Thomas:** Yes, it may well be that there has been a breakdown in particular standards that we would want to have addressed. It may be that there are other things that we would want to look at. These do not need money necessarily; they need actual improvements.

[47] **Mr D. Thomas:** I think that there is a really important question to be asked as to what the phrase 'special measures' means. At the moment I think that it means anything from just weekly reporting through to the removal of functions perhaps. It could be that broad. I think that some definition of that within the context of the escalation intervention triggers that Huw mentioned is going to be important. In terms of building in independence, you will need those special measures, whatever they are, to be enacted quickly. If there is going to be a process to go through to get permission and the approval to do it, then that will slow down the process. So, I think that that is partly why we raise it. First, you should clarify what you mean by 'special measures' and then how they would work in practice and how they would work swiftly where you need to make urgent changes.

[48] **Lindsay Whittle:** Have you had any response from the Minister on that?

[49] **Mr H. Thomas:** Yes, in the sense that the Minister has agreed that this work needs to be done.

[50] **Lindsay Whittle:** Right. Thank you very much.

[51] **David Rees:** Elin has a question.

[52] **Elin Jones:** My first question is to CSSIW and it is on the inspection of integrated health and social care. We know that policy is moving that way, and that the budget is now going to promote that integration of care—reablement services, virtual wards, and care in the home setting rather than in the usual inspected care home or hospital settings. So, how do you foresee the work developing between CSSIW and HIW on agreeing a programme and a process for inspection of integrated health and social care that happens quite possibly outside the usual care settings?

[53] More generally to you all, I heard what you said earlier about HIW focusing a lot of its work and its capacity on its regulation rather than on its inspection work. I had a look yesterday at the reports that HIW have on its website and I was shocked to see how few of those reports relate to hospitals and how many of those reports relate to its regulation work. Therefore, in terms of the post-Francis inquiry work, how do you see that the inspection processes and capacity of HIW, working with your various organisations as well, can be improved and increased to better reflect the kind of expectation that the public has in a post-Francis state?

[54] **Ms Richardson:** That is an excellent series of questions. We could be here for some time. I could give you a very radical answer to the whole business of regulation and where it needs to go in the future.

[55] **Elin Jones:** Go on; I like those.

[56] **Ms Richardson:** Okay. Right. Obviously, there is a White Paper at the moment on regulation and inspection in terms of social care. However, the future is obviously about integrated services that take place within the community, services that take place within people's own homes, and the kind of assurance that the person who is getting the care, the person who is commissioning the care and the families of the person who is receiving the care get. What kind of assurance will they get? Will it be through regulation or not? If you move away from where regulation started, you will see that it started with settings, the size of rooms and a whole area of activity within a setting, which is now well or better understood.

09:45

[57] We also understand that what we have really been looking at are institutions and places, whereas, actually, we needed to look at the quality of the service and what that meant to people and whether it actually produced what was needed for people. If we had regulation that was actually focused, not on the setting and not on the service but on the needs, rights and responsibilities of people, you could have regulation that was portable, in the sense that when a new or integrated service was being promoted, you would say, 'Those are the de minimis regulations that are needed and that is who is best to oversee that'. The rest of the service then needs to be registered, possibly, and some regulations need to be set. However, you do not need more regulation; you need the right kind of regulation and the right kind of checks and balances in the system, and that needs to be a shared responsibility. You have to have somebody who, ultimately, is going to be responsible for coming back to the Government and coming back to policy and say, 'This isn't working; I have the evidence for

you'. So, there is a way to move, if you open your thinking and really think about people's human rights. The Government is looking to change the regulations that we have at the moment. That is not, hopefully, going to mean more regulations, but we should have smarter regulations.

[58] I particularly think that if we followed the rights and duties model, we would look at the other rights of the person to have dignity and respect and to receive information in their own language. What is the duty then of the provider? It is to provide that information, particularly to the person when any changes are to be made in that service, for example if the home is going to be sold, closed and so on. What then is the duty of the commissioner who buys that service to keep that service user informed of any changes that they are making to fees and fee levels, which will make a difference in that care setting? What then is the duty of the regulator? It is to keep in touch and make sure that all of that happens. That is a simple example of the human right, in a sense, to receive information in your own language and in a format that is suitable for you about any changes that are going to be made in your life. So, that is a way of moving forward.

[59] We will, no doubt, until we come to that state of nirvana, work together very carefully to make sure that we do not have any duplication between the two inspectorates, that we are agreed on what our core business is and how we can discharge proper inspections and regulate the sector as it changes in a proportionate, but useful and evidential, way. At the end of the day, you need your regulators to be able to provide you with absolute evidence, not just for the courts, about what is good out there and what is not, and how we can improve to get to that state.

[60] **Elin Jones:** If I may come back on that issue, I completely understand the need not to duplicate between you and HIW. I guess that my major concern then is to avoid that new element of care falling between CSSIW and HIW in the shorter term, before we get to the nirvana that you have talked about. Kirsty talks quite often about the virtual wards system developing in Powys, and it is working elsewhere as well, and I am keen to understand how, in the next year or so, you will make sure that that element of care is not being left to somebody else so that nobody, in effect, takes responsibility for inspecting and regulating it.

[61] **Ms Richardson:** We are always taking a stock take. The market will always develop—ideas will develop and health will develop, but also you will get mission creep into other areas and, suddenly, you start to think, 'How safe is this?' The real dilemma is how safe the care that takes place in someone's own home is and how we have access—we do not have right of access to people's homes. We have to be invited to go into their homes, and we do that through domiciliary care regulations. They could certainly be improved, but it should be made to be more of a co-production with people so that they know that they can come to us and tell us what is going on, and that we can also check very carefully what is going on.

[62] So, really, the two things that you are looking for from us and HIW are whether it is safe and whether it is of good quality. Those are the two things. There are other things that we have to look at, but those are the absolutes, are they not? So, if we focus on those and ask the question, 'How do we get assurance of those two things in this particular service?', we can work it out, but we also may have to come back to Government to have regulations to do that.

[63] **Mr H. Thomas:** From my point of view in the audit office, our role under the Public Audit (Wales) Acts is to look at the extent to which there is value for money in terms of efficiency and effectiveness. Our role, essentially, looks at the governance of bodies. If I use Betsi Cadwaladr as an example, the area that brought HIW and our own resources together was looking at how the impact of that governance was actually being chased down in terms of standard of care, and we identified then the gap between the ward and the board. We relied in that process on HIW's ability to look at the clinical governance arrangements. We looked at

the way in which the board worked, the use of resources and so on, but both were needed together. Yes, there is some overlap, clearly, because clinical and other governance factors come together, but that is why we did the joint review, and that is why, in a sense, we do work on each of the boards at that level. What we do want to rely on, of course, in that process, is that HIW is carrying out its spot checks on various aspects, and is able to tell us its view about the clinical governance arrangements. If we have that, we have a holistic picture. If we cannot rely on that, because of resources, or it is not able to carry out those spot checks, our ability to take a proper look at each organisation suffers.

[64] **Mr D. Thomas:** There is not much to add to that. 'The gap between the ward and board' is an often-used phrase, post Francis, and I think that that was clearly the problem at Betsi Cadwaladr. We say in our submission that there is a real strength in the unannounced spot-check approach, and I think that widening it to get a broader understanding of what is happening at ward level is absolutely crucial. If NHS boards are to know what is going on at their wards they need their own internal mechanisms and external spot checks to give the independent assurance. That is absolutely vital.

[65] **Elin Jones:** So, what you are saying, if I have understood it correctly, is that there is insufficient work, because of lack of capacity by HIW, to provide sufficient evidence for you at a ward level, almost, of issues in various health boards, for you to be able to then step in and work with HIW on overseeing the work between the board and the ward to know whether there are issues that need to be raised externally to the health board. I have looked at the Betsi Cadwaladr report, and some of it I can relate to my own area, possibly—Hywel Dda—and it strikes me that the model that you struck with the Betsi Cadwaladr work, between you and HIW, is a model that could usefully be repeated in a Hywel Dda setting, or possibly other settings. Is there an issue around capacity, especially of HIW, to be able to perform that element of scrutiny?

[66] **Mr H. Thomas:** The issue of capacity goes back to one of my earlier answers. The range of functions that have been laid at HIW's door is formidable. It is not sufficiently resourced to deliver that. It is having to make day-to-day decisions. Many of them are regulations; because they are devolved, somebody has to take them in Wales, and they go to HIW. What I am saying is that I would like to see HIW do more in terms of looking at the spot checks, as we are saying, to give the clinical governance, so that when I report on the way in which the individual boards are using their resources, I actually have a reliable base on which to draw the clinical assurance. That is the area that I would like it to look at. I recognise that, although that is an area that I might like it to look at, others may want HIW to look at other areas. So, I think that there is a need to make sure that you know what the mission HIW really needs to perform is, and make sure that it is adequately resourced.

[67] **David Rees:** We have two supplementary questions, from Darren and Leighton, and then we move on to Lynne.

[68] **Darren Millar:** Very briefly, auditor general, you mentioned the capacity issues, and the ability of HIW to deliver on its huge, broad responsibilities, and to fulfil its obligations. Are you telling us, then, that because HIW does not have the capacity, that there is potentially a risk to its being able to provide the necessary assurances that the quality of care in hospital and other health settings in Wales is good enough?

[69] **Mr D. Thomas:** Shall I take that initially? I think that you would have to be honest and say that there is a risk. We cannot sit here and say that there are capacity constraints and that it is not covering all the bases and then say that there is no risk. It would not add up. It is doing the best with its resources. The spot checks that it has done are really valuable. What we are saying is that there needs to be a broader base of those. Until you get that broader base, there has to be a concern that there would not be an independent view on it. We must not

forget that governance within health boards also has a really important role. You cannot totally rely on the external world to keep finding issues; you have to encourage internal governance systems in health bodies to find these for themselves. That external spot check on top of that can provide you with the assurance that it is happening. I think that we would simply say that there should be more of that.

[70] **Darren Millar:** The move that you took to produce a joint report with HIW was unprecedented—the first time that it has happened in Wales in respect of a health body. Do you think that the problems identified in that report would have been picked up earlier had HIW had the capacity to completely fulfil its functions and role? I think that some of them had been going on for quite a while, had they not?

[71] **Mr H. Thomas:** The concerns that we had been picking up were ones that we had been separately raising. We were not getting sufficient assurances in the responses that we received. That is why we stepped up to a full joint report. You are right that it is the first time in the UK that an audit office and a health inspector have done this kind of work. I would like to see it repeated as a regular part of the ongoing scene in Wales, but I recognise the resource constraints that that means; it took an awful lot of HIW resources to work with us and deliver that report.

[72] **Mr D. Thomas:** I think that the important point is that HIW was aware of the concerns. The trigger for us to go in to do the work was the lack of pace of change. We knew what the issues were, but we were not seeing the health board step up and make the changes that we were expecting. That escalated to the next level of concern for us, which prompted the review. It was not a case of us not finding out about the issues—we had been finding out jointly, reporting back and raising them through our normal channels; it was the response that we were seeing to those concerns.

[73] **Leighton Andrews:** I want to ask the auditor general and the chief inspector to compare the relationship with HIW to their relationship with Estyn.

[74] **Mr H. Thomas:** Estyn is very much a single-purpose inspectorate—yes, it has a range of functions that are in education, but if you compare that with the range of functions that HIW carries out, in terms of its regulation, it does not really merit comparison. In terms of work, Estyn, CSSIW and I—particularly in the local authority world—do work together. We have to co-ordinate our various inspections of local authorities. There is a very clear statutory base for that, which does not exist in health. I think that Imelda refers to that in her evidence. Both Estyn and HIW,with CSSIW and I, are part of a group of four inspectors, and we have tried over the last three or four years to work together in terms of staff training and looking at the various programmes that we are carrying out, to try to ensure that we are not duplicating each other's work. I think that the real difference, if I was to boil it down, is that I have a statutory base for the relationship with Estyn, but I do not have that same statutory base with HIW.

[75] **Ms Richardson:** I do not think that I can add too much, other than that it is about the more work you do jointly, obviously, the more seamless that work becomes. I think that we have had a number of hiccups with HIW because of capacity. I think that the statutory base—as Huw has said—is a very important element, because it is drawn into coverage of so many areas of health work.

[76] **Leighton Andrews:** So, is that a suggestion by both of you—on the statutory base—that there is a lack of definition of the role of HIW, which makes working with it unclear from your perspective?

10:00

[77] **Mr H. Thomas:** There is clarity in terms of the relationship with Estyn and CSSIW in local government that does not exist with HIW. We have tried to replicate that by having the protocol between WAO and HIW.

[78] **David Rees:** Kirsty has a supplementary question on this point.

[79] **Kirsty Williams:** It has been a number of years since HIW was created and, as you said, during that time, new things have been added to it. It has almost been like a repository, with people saying, 'We've got something else we have to do, where shall we put it? We'll give it to HIW.' Do you think, given the concerns that have been expressed this morning about a lack of clarity and a potential lack of focus from that organisation, that now would be the opportune time for the Government to think again about what the functions of HIW should be and look to streamline it and set it on a statutory footing, which you have enjoyed with Estyn and other organisations? Is now the time to say that it worked for the last 10 years, but it is not fit for purpose, as we move forward, for the next 10 years?

[80] **Mr H. Thomas:** There is certainly an argument for saying that we need to revisit and clarify what it is we expect of HIW, going forward, to look at the various functions that it is now exercising and ask whether they belong to that core function or could they be done by somebody else. Indeed, could they be done within the Government machine by another organisation or directly? So, I would want to rigorously look at each of the functions and prune it if it is not essential to the core purpose.

[81] **David Rees:** We will now have a question from Lynne.

[82] **Lynne Neagle:** I have a couple of questions. The first is to the auditor general. One of the concerns that you have picked up in your evidence is that HIW is maintaining a long and aspirational programme of reviews. You highlight the fact that there is a risk, if that continues, that important topics will not get picked up in a timely fashion, or they may be missed altogether. Do you have any examples where that has happened that you can share with the committee?

[83] **Mr D. Thomas:** There are no major ones. We managed the joint work programme quite well between us, but there have certainly been examples where we had the ambition to do a piece of work. One example would be on cancer services, where we pulled that out of our programme because of a commitment that HIW had to do work. That probably has not come through in the way in which we would have expected it to come through. So, there are some examples. I can give an assurance that we work around that quite well with joint working, but the point in our submission is that there has to be a realistic resource-base programme for HIW so that, if it says that it is going to do a piece of work in a certain amount of time, it gets done. That means that, for example, if we see something in the work programme, we have a joint work programme discussion with it and, if it says that it is doing it, we take it out of our aspirations for ourselves; if it does not get done, then an important service area does not get looked at. That is a real risk. So, it goes back to capacity, realism and clarity regarding the core purpose. That is one issue on which we are very keen to see some progress.

[84] **Lynne Neagle:** I also wanted to ask about self-assessment as a tool that HIW is promoting. Once again, the Wales Audit Office has made the point that limited progress has been made with this work. Could you elaborate on that? Also, could we have comments from all of the witnesses on how important a tool you think self-assessment is in driving up standards?

[85] **Mr H. Thomas:** I will speak generally about self-assessment and then I will

comment on where we are in terms of the health area. The Welsh Government had laid down certain standards for health bodies, including governance areas, and we were anxious to ensure that, when we go in, we do not duplicate work. That does not make sense at all. We want to rely on the work that others are doing. So, we have tried to work with HIW in terms of developing a common self-assessment that would provide us and it with information. As we have said, there are some service modules that have been developed, but not right across the board.

[86] **Mr D. Thomas:** I will take one step back. When the healthcare standards first came out, there was a fair bit of machinery around the health bodies' self-assessment and HIW doing some validation against those standards. We could see that, in a lot of cases, the health bodies were calling the standards 'HIW standards', because they associated the standards with the HIW inspection regime. That is exactly the wrong approach and, in fairness to HIW, it recognised that and was trying to embed the standards into the work of NHS bodies through self-assessment, which is why it took them towards the self-assessment process through the modules. If you are going to have that approach, you have to see it through—you have to carry on producing those self-assessment tools to support the NHS bodies doing that self-assessment. I think that is the point that I made in response to the question earlier was that we have not seen as much progress against those as we perhaps would have expected. Some have been developed, we understand. I think that it is a matter to ask HIW about when it comes before you, because we do not have details of its timetable. I think the principle, more broadly, of self-assessment is a very positive one, but it needs the appropriate external validation checks built into it as well.

[87] **Ms Richardson:** I would agree; give self-assessment a statutory function for public bodies. I think Francis was right in saying that there should be a duty of candour in terms of giving an honest account, and for that to be challenged and scrutinised. It is really important that whoever has to produce a self-assessment sees it as their business plan and as being integral to their business, and that it links to their strategic plan, the demographic needs analysis of their business and their medium-term financial plan. It is not just about feeding the regulator—it is about their performance and accountability, first of all to their board, if there is a health board, and then to the regulators. It is a serious piece of work and it needs to be placed in that way.

[88] **David Rees:** Thank you very much for those answers. Rebecca is next.

[89] **Rebecca Evans:** I have a specific question following on from the Wales Audit Office report. You identify that the commentary on mental health services in Wales has been a prominent feature of HIW's work and that, through this work, it has developed significant expertise. How could HIW play a greater role in the development of safe and effective mental health services in Wales?

[90] **Mr D. Thomas:** I think that HIW has done a lot of work on mental health, and a lot of commentary on where things have gone wrong in the tragic homicide cases that have been reported. What we would like to see is an ability for HIW to pool together the knowledge that it has collected from all that work, to ensure that the lessons learnt are promulgated clearly throughout the service. There is probably a good knowledge base in HIW at the moment from that work. The question we raise is how, through its capacity and processes, it is promulgating that more broadly so that people are learning from it, so that you do not keep getting the same reports over and over again, but that you identify the root causes of the problems and address them. We think that there must be a good intelligence base within HIW to do that work, and we would say that that is a key strength that it could bring to the table.

[91] **Rebecca Evans:** Is that a strength of the core team at HIW, or does it rely to a great extent on the pool of experts that it works with?

[92] **Mr D. Thomas:** Its model is based on peer review, so it will rely on external expertise, but it will have core intelligence within its core team, which would have managed and led those inspections. This goes back to the point made earlier about the turnover. Losing corporate knowledge through very rapid turnover as a result of voluntary severance was an issue that clearly affected HIW. You have to look at maintaining that corporate intelligence in an organisation such as HIW and use it to best effect.

[93] **David Rees:** Are there any other questions from Members? Elin?

[94] **Elin Jones:** I will take you back to something that one of you said earlier—I cannot remember who it was. You were advocating the need for a strategic plan on health and social care inspection between the three bodies involved—the two that are here and Healthcare Inspectorate Wales—so that, rather than have individual plans for inspection, you would have a strategic plan that looked at the various issues and that would possibly avoid what you referred to earlier in relation to the experience that you had with cancer audit. I want to know whether you are all signed up to that type of aspiration. How do you think that would work in practice, in terms of developing a three-year plan, so that you would all commit an element of your work—because it would obviously not be the entirety of your work—to working together as three organisations, or two organisations, within that strategic plan?

[95] **Mr H. Thomas:** I think that if there is a clearer requirement laid to share plans and to work together, two advantages flow. First, from my point of view, I am able to plan value-for-money studies in a way that takes account of what is happening over a three-year rolling period. I have to publish the forward programme every year, and so I will be taking that into account. Secondly, I think that that is then reflected in a firmer commitment on the part of the organisations concerned to deliver their share of the plan. As we discussed earlier, there is pressure on the resources that HIW has. We have identified where issues fail because what we anticipated would be in the plan was not there, and we therefore perhaps have not reviewed that aspect of the service at the frequency that we ought to, to make sure that public services in Wales are delivering value for money.

[96] **Ms Richardson:** We have begun the journey, in the sense that we work together as four inspectorates—or three inspectorates and an auditor. The intention is there, but I think that we have to strengthen that, in terms of making sure that we are, as Huw said, delivering two things. One of those is not just conducting episodic inspections, but learning the lessons and applying the intelligence from those. Also, in times of austerity, it is about making sure that we are working smartly together. So, an overarching strategic plan, with our specific plans underneath, would work.

[97] **David Rees:** Do any other Members wish to come in? I see that they do not. I have one further question. You have highlighted very clearly today your concerns about capacity, the statutory framework and the functions that it performs. Is it your view at the moment—or are you concerned—that the current position of HIW is not allowing you to carry out your functions properly, in those elements? Maybe we could hear from the auditor general first.

[98] **Mr H. Thomas:** As I said earlier, what I want to be able to do is to rely on a programme of work. I think that the pressure that it is under means that I cannot rely on it 100%, and gaps therefore occur. That is, in a sense, where I am focusing.

[99] **Ms Richardson:** I have to say that I always make sure that we can do our work. I have access to a fee-paid panel of inspectors who come from a wide range of professional backgrounds, so I can always ensure that we can cover the ground. Obviously, however, my preference would be to work with HIW more closely.

[100] **David Rees:** The last question will be asked by Elin.

[101] **Elin Jones:** I wish to press you on an issue that I raised earlier, on the joint work that you did with HIW on Betsi Cadwaladr University Local Health Board and the gap between the ward and the board. Does the Wales Audit Office consider that that model of work should be replicated—capacity and time-allowing—for other health board areas?

[102] **Mr D. Thomas:** Yes, but on a risk basis. It would be erroneous to say that all of the issues that we identified in Betsi are replicated everywhere. There was a set of very specific issues happening at Betsi Cadwaladr health board that prompted that particular review. However, what it showed was the complexity of the health boards, as they stand. The governance arrangements are complicated, and they therefore hold a risk in terms of having an internal infrastructure that gives them the intelligence to know what is happening at ward level. So, there is a value in doing it, but I would advocate a risk-based approach, so that the challenge on us as external reviewers is to develop that intelligence to know when those risks and triggers are starting to raise concern. That is the work, which Huw referred to earlier, that we are doing with HIW and the Welsh Government on the development of that escalation process. That is absolutely vital, I think, because we need the whole system to give us that intelligence, which might prompt a joint review elsewhere. You could have a rolling programme of them, but I would strongly suggest that it should be risk-based, not based on an assumption that what happened at Betsi could happen everywhere. The way that we work at the moment gives us that intelligence, I think. We have our systems to know when a set of concerns is being raised. It would be nice maybe to formalise them a bit more, which is what we are doing at the moment as a result of the Betsi work.

[103] **Ms Richardson:** I will just add that I also think that any model or protocol needs to have a read across from health to social care. There needs to be connectivity, rather than setting up two different models.

10:15

[104] **David Rees:** I thank the auditor general, Huw Vaughan Thomas; Dave Thomas, the director of health and social care at the Wales Audit Office; and Imelda Richardson, chief inspector—correct this time—of the CSSIW, for your evidence this morning. I once again apologise for the technical problems that we had at the start, which I know caused difficulty. Thank you very much for persevering with us. You will be given a copy of the transcript for factual correction if there are any issues. Thank you very much once again for attending today.

10:16

Ymchwiliad i Waith Arolygiaeth Gofal Iechyd Cymru: Panel 2—Cynrychiolwyr Byrddau Iechyd Lleol
Inquiry into the Work of Healthcare Inspectorate Wales: Panel 2—Local Health Board Representatives

[105] **David Rees:** I welcome our next witnesses, Andrew Goodall, who is here as the chief executive of Aneurin Bevan Local Health Board, and Carol Shillabeer, who is from Powys Teaching Local Health Board. Thank you very much, both, for attending and thank you for your written evidence. I will give you an opportunity to talk about your working relationship with HIW, and then we will go to questions from Members.

[106] **Dr Goodall:** Good morning, Chair. Bore da. Thank you for the opportunity; I am very grateful to have the chance to come and talk to you here. I have a couple of opening

comments and I am very happy to take questions. We are both here recognising the importance of the regulatory function and how it needs to work, but it is probably worth exploring how the environment around us seems to be changing and how we need to adapt to that. Certainly, we have to do that as health boards. Equally, that is probably true of Healthcare Inspectorate Wales.

[107] I want to comment in advance that one of the strengths that I have seen from Healthcare Inspectorate Wales is around being very transparent about the investigations that are done and the reports that are issued. It would be good to build on that work in terms of how we learn more in Wales. It has taken on an increasing agenda over recent years, so capacity seems to be something that we need to focus on more, if it is to discharge properly the regulatory function.

[108] Chair, I just want to make a general comment that Carol and I are very happy to act as general representatives of NHS Wales, but of course, as necessary, we can revert to speak about our own organisations' experiences, both for Powys and for Aneurin Bevan health board.

[109] **David Rees:** Thank you very much. Carol, do you wish to make any comments or are you okay with that?

[110] **Ms Shillabeer:** No, I am very happy with what Andrew said. I am happy to take questions on the broad range of the regulatory function.

[111] **David Rees:** Okay, thank you very much. We have the first question from Gwyn, followed by Kirsty.

[112] **Gwyn R. Price:** Good morning, both. Do you share the concerns raised by the WAO regarding the operational independence and autonomy of HIW? Can you expand on what you think of that?

[113] **Dr Goodall:** It is not a concern. It is about basing it on experience. The reporting arrangements into Welsh Government are part of the establishment of Healthcare Inspectorate Wales in the first place. I have seen HIW being able to assert a very independent voice through that process. Of course, it has a responsibility to respond to areas, not least those that the Minister may highlight, if there are some concerns, but it also discharges a number of regulatory objectives and I have not had a sense that it has compromised the areas that it needs to get into—certainly not on the basis of my own experiences. That has included having to go through, in some detail, a homicide review locally. I found that Healthcare Inspectorate Wales absolutely focused on the right issues; it balanced its criticism, it discharged it very professionally and I felt that it was discharging a very independent role and perspective.

[114] From a structural perspective, I think it could certainly be seen to be a concern. I guess, as we look to what the future represents for Healthcare Inspectorate Wales and the need to adapt, that would be something I know the committee would have its own thoughts and views on. However, on individual themes or areas or on unannounced visits, they pretty much say what they think and they share it with us at this stage. So, it is probably a concern about the concept of it, perhaps, given how I have received it in practice.

[115] **Ms Shillabeer:** I would support what Andrew has said. In practice, HIW appears independent, in view and in action. It is helpful that it is not setting policy and that there is a clear distinction between different organisations: the HIW is here to inspect and regulate, and that appears to be pretty clear to the service, based on what I have seen and experienced too.

[116] **David Rees:** Gwyn, did you want to follow that up?

[117] **Gwyn R. Price:** Yes. On the role of the HIW vis-à-vis the role of the community health councils, you seem to indicate that a bit more clarity could be achieved.

[118] **Dr Goodall:** Yes. This is potentially where we have different parts of our system that can run into each other, but, for me, it is probably more about being clear about how they can complement each other, because they bring different perspectives to the table. Certainly, in the area of unannounced visits, both have roles to turn up on our different sites and services and to form their own views and assessments about what they see. From a HIW perspective, it is not that it is just overly random, but HIW can simply choose anywhere that it wishes to go to. The community health council will tend to have a lot more contact with us on a more frequent basis, and it will have other data and intelligence that it can share with HIW, perhaps about areas of concern that it has explored, and it is doing a far more frequent set of announced visits. So, as I said, it is probably that there is the potential for them to run into each other, but, moving forward, it is probably a real advantage for Healthcare Inspectorate Wales to draw in the CHCs, to some extent, while still protecting the independent role of community health councils. I noted some of the comments that were made in the CHC submission, and I think that there was a genuine offer on the table there to say that there is far more information about the local services, and the views on those services, that could be brought to the table.

[119] **David Rees:** The CHCs are coming in afterwards. Carol, did you have a comment?

[120] **Ms Shillabeer:** I can give you a practical example, where the CHCs have done unannounced visits in my patch in Powys and the following day HIW have been there, and, almost the week before, I was doing my visit. So, there is something in trying to co-ordinate the unannounced visits. I think the CHC has quite a lot to offer in this regard. The other big issue for me around the CHCs is the wealth of general knowledge and intelligence around the healthcare settings and whether HIW could maximise that through much closer working. One of the things that I have observed over the years is the capacity of HIW to engage with the public who are using the services to get a sense of what some of the issues are so that, when they are visiting and undertaking their field work, they can be a bit more targeted around that. So, there is some real scope around coming together.

[121] **Gwyn R. Price:** Joined-up writing.

[122] **Ms Shillabeer:** Yes.

[123] **David Rees:** Lindsay, did you have a supplementary question on this point?

[124] **Lindsay Whittle:** Yes. Am I missing the point, or is not the whole issue with unannounced visits that the inspectorate will see things as they are and not as they are planned? I want an inspectorate to see things as they are, to walk the corridors, to talk to the patients, run their fingers along shelves and check that people are using hand gels. I want them to do the whole kit and caboodle. What is your view on that?

[125] **Dr Goodall:** My comment would be that my response was not to say that unannounced visits should not happen, but that there should be some sharing of the areas of specific concern or of areas, perhaps, where the community health council had gone in and had expectations to address. I think that HIW has a role to be the eyes and ears of our community, but there are other colleagues, and community health councils are included in that, who would equally have that role to discharge. However, it is not about preparing for visits. I think it has been a real advantage to know that at any time you can get calls. I have had three or four of those over recent weeks or so, that range from radiology and some of the more statutory expectations around that, to individual mental health ward visits. The

expectation should be that we should be maintaining these standards on all occasions, but we do require an external perspective, I think, as well as having our own responsibility to work that through locally. I would not want you to have any sense that we feel that unannounced visits should not happen or that there should be some advance co-ordination of it, but I think that a sharing of the intelligence about where concerns lie within individual hospitals or services is an area that the CHCs could add some strength to.

[126] **Lindsay Whittle:** I will quickly follow up on that, and then you can delete me, because this is my question, Chair. Have you found any examples where it is difficult to obtain any advice from Healthcare Inspectorate Wales? Does it come back to you efficiently? What is your dialogue with the inspectorate afterwards?

[127] **Dr Goodall:** I have had some mixed experiences, which means very good examples of immediate responses and some examples where it has been on the slow end. I think that we have to respect that, in some of the very significant areas that HIW will get into, such as a homicide review, that will inevitably take a very long time to work through, because a very critical level of detail is gone into and HIW is tracking back, usually, the whole history around an individual patient's experiences. I think that we need to allow for the fact that HIW needs to work through that. We find a number of examples where things come out immediately, but I know that there have been some frustrations that the report on an unannounced visit has been received much later, sometimes as much as 12 months later, when we have addressed the area and moved on, but then the awareness is out there in the community, which can, of course, cause some concerns. So, I think it comes back to my earlier point, which was to ask whether, as HIW has adopted a series of other functions and roles, we have also allowed it to grow its capacity to be able to deal with this and to respond. I want to have an immediate response, because that is the pace and urgency of the environment that we are in, but we also need to be able to facilitate that through its functions.

[128] **David Rees:** Carol, would you like to add to that?

[129] **Ms Shillabeer:** I would echo what Andrew has said. There have been mixed responses in terms of timeliness. We have recognised that the time limit for reports following unannounced visits is problematic. If I were to ring and ask for a bit of advice about a service that I might be a bit concerned about, I can usually get a pretty quick response. There have been delays in some areas, such as Mental Health Act monitoring, which I think HIW has identified for itself and is now picking up. So, it is a bit patchy, really, in terms of the capacity and how that capacity is spread throughout the organisation.

[130] **Lindsay Whittle:** So, it needs a little bit of tightening up itself, then, you are saying.

[131] **David Rees:** I will allow one final supplementary question on this point, and then we will move on to Kirsty.

[132] **Rebecca Evans:** In responses to written consultations, we have had evidence that front-line staff are made aware of when unannounced spot checks are going to take place. Obviously, I will be raising this with HIW, but, as representatives of the health boards, can you explain how that might be the case?

[133] **Ms Shillabeer:** I am not aware of that. In my experience, and from talking with my colleagues, we certainly have not been aware of when unannounced visits are to take place. What HIW has done is to use reviewers from within the service. I would imagine, although I cannot confirm it, that there are very clear confidentiality agreements in place. If those need to be revisited, then they surely must be, because we cannot undermine the integrity of the whole inspection regime, but I have not heard that, and I have not observed it in practice.

[134] **Dr Goodall:** What will tend to happen is that I will get a call to my office at 9.10 a.m. to tell me that the review team is already on site. The team will confirm which ward it is on and will say that, as a matter of courtesy, it is just letting me know that it is requesting somebody senior—in the professional structures, usually—to help escort it around. We do our own visits, which are part of our own local assurance mechanism, for example, patient safety walk-around visits, where the board will look to discharge some of these functions and do our own tests. Those will tend to be areas that are highlighted to our staff, but my experience of HIW visits is that we simply do not know and we are not prepared for them.

[135] **David Rees:** Thank you. Kirsty is next.

[136] **Kirsty Williams:** May I come back to the point about whether the functions that the HIW now has—as opposed to what it initially had when it was set up—mean that we have an organisation that is fit for purpose? I wonder whether you think that a review, a simplification and a clarification of what the core function of this body is would be appropriate at this time and would assist you in your aspirations to deliver high quality, safe services. I am also interested in using the work of HIW as a tool for learning within organisations to avoid failures in the future. There has been some criticism that serious incident reviews are carried out and yet there is little or no evidence of follow up on the part of HIW to ensure that local health boards have amended their policy, behaviour and practice, and I wonder whether you can say, 'Well, no, that is not the case', because there is no evidence of that that I can see, and freedom of information requests from other organisations will demonstrate that there is no evidence. I wonder also whether there is any evidence to suggest that, if a review is carried out in a different organisation and part of the NHS, the learning experiences from that are disseminated across the patch. So, if something happens at Betsi, is there an opportunity for you to understand and to learn from that and apply that to your own organisations, because, surely, it would be a key job of HIW to do that?

10:30

[137] **Dr Goodall:** I will start with your second question, if that is okay. On the one hand, as health boards, we have to try to draw in as much of the knowledge out there as possible; so, if we know that there will be advice or recommendations that are being given generally for NHS Wales and across NHS Wales we can go to HIW ourselves and we can go to its website and try to draw on this information. However, in the midst of lots of different responsibilities, there is the danger that we do not focus sometimes on the right issues or report that can have some quite serious effects across the different health boards in Wales. So, moving forward, a greater focus on how we disseminate the good practice, the best practice, or certainly the lessons that are learned, for me, should be a core function of Healthcare Inspectorate Wales, again, probably along with the capacity to discharge that. However, I think that there would be a real advantage to doing that more strongly. Interestingly, before I arrived in my post we, sadly, had had a couple of mental health homicides in my area, and one of my first duties as the chief executive, in my first week, was to speak very publicly about the outcome of the homicide review that had occurred. One of the discussions that I did have with Healthcare Inspectorate Wales afterwards was—of course, we have had a number of these before across Wales, and there are always individual issues, but there are lessons to be learned—about how we can promote that more strongly. Actually, we did a couple of things just on the back of that. We did a thematic review of homicide reviews. We shared that among the different organisations in Wales and actually took it to the chief executives as a very personal group, but we also facilitated some workshops where some of the learning, and certainly the experience that we have been through on that process, could be shared more broadly. I do not necessarily think that that is a matter of routine, however. I think that that was because we acknowledged some of the special circumstances that existed there.

[138] In terms of organisations learning, clearly, as we have unannounced visits occurring

in our own organisation, we will look to share those to make sure that our expectations about standards for cleanliness, for example, are made very visible across the organisation so that it is not just about a ward having its own action plan, but about making sure that people understand the standards that we are looking to apply more broadly. So, we can develop our own mechanism for learning, we have a learning committee, and we have the ability to go to ward sisters' meetings and to actually speak to some of the individual staff involved. However, if your question is, 'Can we can do more to promote and share good practice, highlight that and do the lessons learned?' I think that the answer is 'yes'.

[139] **Kirsty Williams:** My issue, though, is not with the LHBs; my issue is whether HIW is ensuring and asking you whether you have done that. It seems to me that you said, 'I can go to look at its website. My organisation can read its reports'. So, it is very much on the basis of your organisation doing that. I am interested in what HIW is doing to ensure that your organisation is doing those things. My concern is, if you have a proactive organisation that it is seeking this out, it happens, but there is no-one from HIW making sure that it is happening.

[140] **Ms Shillabeer:** I think that there are two different things here. In part, HIW does follow-ups. Where I have seen evidence of follow-ups has been where there have been thematic reviews, such as the management of diarrhoea and vomiting, for example, CAMHS services, or youth justice, where there has been a collaboration with other inspectors and regulators, and a thematic national report has been published. There will be a follow-up to that, and that is very helpful and demonstrates progress or otherwise. Where I think that there has been a lack of follow-up has been where there is an individual inspection. What has been clear to us as a health board is that it is our responsibility to implement the action plans and to demonstrate that we have done so. HIW does not appear, whether it is its role or not, to have been able to come back to us to check on all of those. However, it would be wrong to say that it does not follow up on other, core pieces of thematic work.

[141] **Dr Goodall:** Obviously, if there are significant concerns—again, in the transition to our new organisation, we were working with HIW under special measures for maternity services at the time. There was a very clear follow-up mechanism. There was a weekly assurance mechanism, and the action plan was pursued, not just when it had been signed off, but a few months on as well just to make sure that we were still embedding those practices. Even at this stage, I think that it has led to a far more proactive discussion with HIW, where we will share our own concerns on individual issues as they occur.

[142] You also asked about the functions and the spread of functions going forward. I think that even coming into this review process is a good reminder to all of us of the breadth of areas that HIW has taken on over the years. You can take its overriding aim about overseeing the quality and safety of services in Wales, but it is actually more specific than that. With regard to some of the individual detail that is required on areas such as radiology protection issues, these are very technical skills that are actually necessary at this time. So, in terms of a refresh—and I cast it in the light of the learning that we need to do as a service about the Francis recommendations et cetera—I think that it would absolutely be right to focus on what the core objectives are, but, again, to make sure that the capacity is lined up, and the understanding to take that forward.

[143] **David Rees:** Darren has a supplementary question on this issue, and we then move on to Lynne.

[144] **Darren Millar:** I have a follow-up in terms of serious cases that might occur in one part of Wales—nowhere near your own—and this need to learn from those. The Wales Audit Office, of course, has a thing called the good practice exchange, which I know that both your organisations will participate in, as far as value for money is concerned. Is there a similar sort of exchange available to share good practice when something that HIW has brought into the

light has occurred?

[145] **Ms Shillabeer:** I think that I can say, certainly from a health board and trust perspective, that there is a very close network of risk managers, and quality and safety managers, who will pick up those issues and learn across the piece. There is certainly interaction at a very senior level in terms of the quality and safety forum, where the Welsh Government, the regulators, and the service are together, and those key issues emerge as agenda items and an agreed way forward. Therefore, whether it is on diabetes management or on care for people with dementia, those thematic issues come up and they get addressed. I am not aware that there is something similar to the good practice exchange.

[146] **Dr Goodall:** I like and use the good practice exchange, because I am quite happy to learn from other people about things that we can change. However, we have to go looking a little bit for the information in that way, so I think that that will be a positive promotion, if we could have something, or, indeed, align it with the other regulators through the good practice exchange mechanism—I do not think that we need to invent something.

[147] **Darren Millar:** Okay, thank you.

[148] **David Rees:** Lynne Neagle has the next questions.

[149] **Lynne Neagle:** Thanks, Chair. I have two points. You will not have heard our previous evidence session, with the Wales Audit Office, but one concern that the auditor general expressed was about the operational independence and autonomy of Healthcare Inspectorate Wales. He suggested that that might be an area that we might need to look at reviewing, particularly in relation to the relationship with the Minister. I wondered whether you had any comments on that. My second point is on self-assessment. We have heard that Healthcare Inspectorate Wales is moving towards more of a self-assessment model of doing things, but some of the health boards have expressed concerns about that as a way of monitoring standards. I just wanted to ask for your views on that.

[150] **Dr Goodall:** On the governance and the oversight role, I agree that there are choices about how it is located. In answering the first point that was posed, I said that, in my experience, I do not think that I have felt that it has suppressed Healthcare Inspectorate Wales to say what it wanted to say—I do not think that it has held it back from areas where it has had genuine concerns, and we have had to demonstrate what we are doing about that. However, I can understand the aspect of it being hosted within the Welsh Government, with the ability of the Minister to ask for certain areas to be picked up in that way, which would maybe seem to be not as independent as it could be. Therefore, I think that I would just acknowledge the auditor general's comments, and say that I think that that is probably something that the committee may have its own views on. However, in practice, it feels that it has an independent perspective, and I certainly know when I have been the subject of a HIW set of recommendations.

[151] On the self-assessment role generally, I think that there are positives about the self-assessment mechanism, as in allowing us to take responsibility for our own areas. However, it has to be part of a clear understanding about where any regulator is going to step in, that, where they have a concern on any aspect of the self-assessment, they are able to come and explore it, and actually seek the evidence base. I think that, thirdly, any self-assessment that is done by an organisation needs to be triangulated with other sources of data. I think that this is one of the advantages of working with the other regulators, and having their annual summit, and sharing some of that information. I would certainly welcome knowing more about the concerns that are expressed in that forum, so that we can do something about it. However, it would also be about opening out a little bit more, and perhaps drawing in other sources of intelligence, as I said earlier, such as the community health council, or the Commissioner for

Older People in Wales, where it would seem that there are other sources of information at this stage. I am an advocate of self-assessments, but, if they are just left as a self-assessment process on their own terms, they can be a danger to any organisation as they can lead to complacency in the worst situations, and you need that external perspective to be brought. Therefore, I think that it has to be self-assessment with teeth.

[152] **Ms Shillabeer:** I have a couple of points to add to that. In terms of the model of operating, and self-assessment in its own right, I agree completely with Andrew about the level of ownership that we have with self-assessment. However, there is some evidence that says that, if you just rely on self-assessment, there is a likelihood that you are overly positive, so you need to have that level of scrutiny.

[153] I have a couple of comments in terms of things for you to think about. It is important to have external expert reviewers that come in and are quite targeted and focused on the areas of concern. Also, ensuring the triangulation of the evidence is critical. I have heard some concerns around, for example, the unannounced visit. The visit is a piece of field work, but there have been question marks around whether there has been any documentary evidence gained previously to support the visit or whether the views of people, particularly from the CHC, have been picked up.

[154] A general comment around the model for operating, and this is probably reflective of a capacity issue, is that, in the old days, we would have had an organisation-wide inspection picking up, or joining all the dots, of the issues of concern and laying them in front of us. It has, over the last few years, become pretty targeted, and this relates back to Kirsty's question about core functions and whether HIW has been stretched too far to enable it to join those dots up, or whether the joining of dots should take place with other regulators and other bodies that also have a role in reviewing our work. I hope that that is helpful in terms of the model of operation.

[155] **Lynne Neagle:** In relation to your reference to external reviewers, that is an area where CSSIW has made a possible criticism of Healthcare Inspectorate Wales, in that it may be over reliant on external reviewers and that that can mean that the core team can sometimes appear short of knowledge and experience. Have you had any experience of that?

[156] **Ms Shillabeer:** I have a view on it. The very nature of healthcare is extremely broad and there are a number of specialties. It is not reasonable to expect any employed reviewer within HIW to have a really comprehensive knowledge of all of the areas of practice, hence the need to bring in expert reviewers. I am sure that there is an important point in there about getting that balance right and ensuring that you are not overly dependent on recruiting external people. Balance is also needed in making sure that there are sufficient lay reviewers, to bring that fresh pair of eyes. The models of operation in CSSIW and HIW are very different, and possibly for a very good reason.

[157] **Dr Goodall:** I was interested to read the other submissions. The CSSIW, in some respect, is the part of the world that we do not necessarily see. I guess that that is where regulators have had difficulties as regards pushing at the pace they wanted. By the time visits occur, from our perspective, everybody has been lined up, the reviewers are in place, and we probably have not necessarily seen that kind of difficulty outside of the health board.

[158] **Kirsty Williams:** On the issue of operational independence from Welsh Government and Ministers, if HIW wants to put a service or an organisation into special measures it can only do that following permission from the Minister. That is not the case for schools or local education authorities, where Estyn will just turn around and say, 'That is special measures for that school or that organisation'. Do you see any merit in retaining a system that allows the inspector to put a service into special measures only with the permission of a Minister? Are

there any merits in retaining that system?

[159] **Dr Goodall:** We deal with lots of different regulators. We are used to dealing with the Wales Audit Office. If it has a concern then it will tell us and we will respond. On Healthcare Inspectorate Wales, we were subject to the special measures aspect, as I said, in the transition to the health board. That had been approved by the Minister, but it had already had a discussion about its intention that we would be put in special measures at that particular time. Reflecting on the Francis environment we are in, our system is learning all of the lessons of that. It is definitely a discussion to be had at this stage. I do not see a problem in the current system as it works, but if you do not deliver it properly it can seem that we are trying to filter out some of the broader concerns that are being expressed. From an organisational perspective, if somebody has a concern, I would rather that they tell me and then I will try to act to respond to it.

[160] **Kirsty Williams:** So, you do not see any merits. Nothing springs out as to why this system is the right system and we should be careful about moving to a system where it would just be able to put you into special measures.

[161] **Dr Goodall:** It just happens to be the system that we have operated. I have seen special measures being used as part of the tools and methodology. I do not get the sense that anybody has suppressed any other concerns and not come to us on any other basis. I just accept that the current system requires ministerial approval. I can see advantages and disadvantages.

[162] **David Rees:** We heard earlier from the Auditor General for Wales that they were looking at special measures and clarification about what that actually meant and what could be achieved as a consequence.

10:45

[163] **Ms Shillabeer:** I would add that there are some important messages in the Francis report. Being clear that regulators have that voice of independence right the way from policy setting into practice has been picked up. That is not to say that Wales has suffered negatively from the current arrangements, but that is a statement that was made and I am sure that it should have some due regard in consideration.

[164] **David Rees:** Okay. We have questions from William, Darren and Elin.

[165] **William Graham:** Healthcare Inspectorate Wales clearly wants a process of modelling standards on a self-assessment basis and it simply does the validation. Have you encountered any particular problem with that? There is criticism that there has been a loss of added benefit and the opportunity to benchmark with other LHBs. Has that been your experience?

[166] **Dr Goodall:** The healthcare standards were a very strong basis for HIW in the previous organisations in Wales, when I was a chief executive of LHBs in the previous reorganisation. I think that we took it into the new health board perspective. Some of the focus of HIW has become targeted—for example, if it was mental health, or then doing something on radiation. I would welcome a broader outlook, taking account of the healthcare standards, which allows us to facilitate the healthcare standards. Carol was reflecting on both of our experiences in the previous system, which is that it was a really good source, with a far broader set of feedback to the organisation. Equally, the self-assessments were not simply just accepted, so, you were taken through a process of having to demonstrate the evidence base at that stage. In general terms on healthcare standards, I would see that as something that could be improved moving forward.

[167] **Ms Shillabeer:** My only comment on that is about ensuring that there is a balance between being proactive and reactive. The healthcare standards provide the ideal opportunity for being very proactive and testing. The current work that HIW has been doing has tended to be more reactive. Again, I feel that it is a capacity constraint issue and about this need to fulfil multiple functions. So, I am pretty sure that there is more to be done around the self-assessment and the broader base of work.

[168] **William Graham:** Aneurin Bevan LHB says that it has a positive relationship with HIW that is appropriately challenging and constructive, but also developmental. However, Hywel Dda health board said that there cannot be an over-reliance on self-assessment as a process for health boards to demonstrate their effectiveness. How do you reconcile the two?

[169] **Dr Goodall:** I feel that, as we came into being in the organisation, when you are in weekly special measures meetings with your regulator, you have to work through those issues, possibly in a very different way. You could argue that that might have felt like that was a negative context, but it was a little bit of the regulator needing to look us in the eye as a new team and believe that we were going to move things on, and track and monitor the progress.

[170] Therefore, I accept that health boards would have had different experiences. However, I also acknowledge that having had to be part of publically discussing homicide reviews that had taken place at the time, the team was very challenging, and, appropriately so. It had an expectation not just that the health board would respond because, obviously, the jurisdiction then applies to other partners, such as social services. I would not want Members to feel at all that that was an easy process by any means. It is a very significant event that occurs in any organisation. I felt that it was critical on the right issues but, at the same time, it allowed us not just to make it wholly about blame, but to demonstrate how our system and approach needed to change more generally, as well as deal with some of the clinical practice issues that had been highlighted.

[171] **Ms Shillabeer:** I do not have any specific examples from Powys, but I certainly concur with what Andrew says around the special measures. When I was in Gwent, it was pretty challenging and exacting in terms of seeing the improvement. That was an area where field work was followed up in some detail, and it did not just to take our words for it that we had made improvement, but actually saw, visibly, on the ground that we had. So, there is some real evidence that it gets its teeth into things and is pretty tenacious about it.

[172] **Darren Millar:** One of the big issues at the moment is patient confidence in the NHS, as a result not just of the Francis report over the border in England, but of some of the problems that we have had here in Wales. What role do you think that HIW needs to play in helping to restore patient confidence? Many people out on the street do not know what HIW stands for, and they have no idea what its role is in terms of holding health boards to account for the quality of work that they deliver. I would just be grateful to know whether you think it should have a bigger public profile in being able to celebrate good practice, condemn bad practice, and improve quality overall.

[173] **Dr Goodall:** I would reflect that it seems to have become more specific rather than broader. Certainly, when we were going through the previous healthcare standards assessments, I think that it had a different visibility, publicly and locally, and boards were receiving HIW very formally, and there was a process around it. I think that we can make assumptions that everyone understands who our regulator is, and who HIW is, and, whatever our views in the service, I think that probably the public would not necessarily broadly understand it—they would have seen an association with things such as homicide reviews at this stage. It has a broader assurance role, of course, around the quality and safety of services.

I think that we probably need to work on the communication of its role and its objectives, but there has to be more visibility.

[174] I think that the danger of having a system that is wholly reliant on self-assessment by boards is that it does not matter how seriously we take it as individual organisations, it is the external perspective that will give people that confidence. So, I personally would say that that should be a very assertive role for HIW to take on, but I would also want to move it towards allowing us to say how we promote everything that is happening, around all of the healthcare standards that have been set for us, rather than just drop into one or two individual examples of a failure or a need for improvement, at this stage. On the good practice recommendations, and getting it out there, and showing the public how we are learning from each other, I also believe that that is one of the roles that it can discharge very effectively in the future.

[175] **Darren Millar:** The Auditor General for Wales will table his reports before Members of the National Assembly. If Estyn puts a school into special measures—it does not matter where it is in Wales—it is headline news. However, whenever a health board enters special measures, under an arrangement with HIW, it does not seem to feature anywhere. Is there a problem in terms of its public interface, in that respect?

[176] **Dr Goodall:** I know that the homicide review, for example, was a very visible process, with local contact and so on—

[177] **Darren Millar:** Setting aside the homicide review—

[178] **Dr Goodall:** I think that it is a very specific example of where it does it. I think that, more broadly, although the information is presented in the public domain, it attracts less of a focus, for whatever reason. The way that we try to compensate for that is to ensure that, in our own board mechanisms, we do receive it—and publicly so—and we demonstrate our action plans, and we do receive them in the public environment. That could be promoted more effectively, but we also need to understand why it is not being picked on in that way. Personally, I think that part of it may be that, if it is part of the annual and a broader assurance process for health boards that is drawing everything and putting it onto the table—and that may be alongside other regulators—that might be an opportunity to promote it in a slightly different way.

[179] **Ms Shillabeer:** If I can add a comment, I guess that, for the public, what they see on the television, are a number of different people commentating on the health service. So, you will have the Commissioner for Older People, you will have the Public Services Ombudsman for Wales, you may even have CSSIW—and I wanted to raise a point later, if I can, about regulatory gaps or overlaps—and you may have the Health and Safety Executive. So, it is actually quite a full picture. In terms of understanding where HIW comes in, there may be something about having a greater understanding about regulatory touching points, and who is doing what. However, I would agree that the profile does appear to be lower than say, for example, Estyn.

[180] **Darren Millar:** I wanted to come back on a separate issue, but I can see that other Members have questions.

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

[182] **Leighton Andrews:** I am not sure that I buy that response. In education, you could argue that you have the Children's Commissioner for Wales and a whole series of other people commenting on education. Is part of the issue here that the statutory remit for HIW is not as clear, maybe, as for other inspectorates?

[183] **Dr Goodall:** I have been interested to look at the various submissions that you have had this morning, because it informs me slightly, and I think that there is something there to ask whether it is as clear-cut. HIW's general role about discharging assurance around quality and safety is very broad indeed, of course, on the one hand. I think that the extent to which the individual technical detail, as I said, of going into areas such as radiology means that it has a very specific statutory role to be discharging in those areas around assurance. However, just some of the responses that we have had this morning may say that it is not as clear to everyone around the table, and it may not be always clear to us within the service, because of the spread of responsibilities. However, to take that into the public arena, and to try to define it, is quite difficult.

[184] **David Rees:** On your last question, on the top line, you have also highlighted that the reports are sometimes very late coming back. Is that also an issue, because, by the time that the report comes to the public domain, and the board has to respond to it, you may be 12 to 24 months down the line? Therefore, it may not be seen to be, in a sense, public news.

[185] **Dr Goodall:** It is not always the case, but it has been the case, and not just on a one-off occasion, that we receive those reports later. However, as I said earlier, if the public receives the views of an unannounced visit that took place 12 months ago, and somebody is going into that ward environment, when we know that we have been in there, we have accepted the recommendations and we have even refurbished the area, it will obviously add to public anxiety in terms of when the publicity is attracted. So, I think that the expectation on us, on the service side, is about the timeliness of our responses and action plans and making sure that they are discharged. I guess that, for any regulator, it really should be the same principle: that we should be looking for timely oversight, but also timely publication.

[186] **David Rees:** Leighton wants to come back quickly on this.

[187] **Leighton Andrews:** I just wanted to ask explicitly about the inspection of GP practices and whether you saw that as coming within the remit of HIW.

[188] **Dr Goodall:** Arguably, it does, within the broader expectations of the NHS, but, in reality, it does not. Partly, that is because of the contractual relationship that we will have with the GPs, rather than being simply about the oversight of our individual services, although there are other examples of contractual relationships, not least with care homes and nursing homes, that we have to similarly work through, and there can sometimes be a little bit of a grey area between CSSIW and HIW there. We have community health councils stepping into that a little bit, with an expectation that they are part of visits, but these are services that are discharged within the NHS, and I think that if there are concerns, our regulator, of course, should be able to pursue them. So, clarity around those contractual relationships is probably important, but there will need to be a methodology that allows for that. I can give you an example that I have been working through with HIW, where, at my request, it has been helping out with a particular issue, and it does involve the primary care arena. So, actually, we have gone in there and looked at and explored some of the primary care aspects, but its process of unannounced visits, for example, does not necessarily apply to primary care; it will apply to our hospital sites. Community services need to be drawn in, in the same vein. They are arguably under the general auspices, but they are not dealt with specifically. I think that we both raise issues about how we deal with integrated teams, where you have local authority staff alongside health staff, working together, and we probably need some clarity there as well.

[189] **David Rees:** I am conscious of time. I will ask Elin to come in first and then come back to Darren, if we have time.

[190] **Elin Jones:** I was just about to ask about integrated care, virtual ward models and

healthcare happening in homes—increasingly so—and whether you had any ideas of how you think inspection work could be more focused between CSSIW and HIW on that new element of care. Very quickly, also, on issues that were discussed earlier with the Wales Audit Office on the joint approach towards inspection with the Betsi Cadwaladr report that looked at the relationship between board and ward, I wondered whether health boards thought that that kind of model would be a good model to pursue with other health boards. The response from the Wales Audit Office was that it thought that yes, it would, but only on a risk basis, as in it would want to assess risk rather than have a general programme. So, I wondered whether you had a comment on that.

[191] **Dr Goodall:** Okay, do you want to take the first question and I will take the second?

[192] **Ms Shillabeer:** Thanks for asking the question, because it is something that I did want to try to cover. I am very interested in the whole issue of integration and regulation. Just to give an example, to bring it off the page a bit, we have recently in Powys been developing our health and social care service in Builth. We have a building and there are beds within that, and we have a model where patients may come in for a short stay into the health and social care centre. That is collaboration between health and social care. When we were establishing this model, we were thinking about which body was the regulator and what the regulatory framework was. I have to report that my experience of working with both CSSIW and HIW in answering those questions was very positive. They were very clear in saying to me that, 'The needs of the population are foremost, the service that you've put in is entirely appropriate, and we will sort the regulatory framework out around that'. As integration becomes far more embedded and part of the norm, there may be a need to revisit how the regulators work together, if they continue to be separate in the longer term. So, my experience has been positive, but we recognise that there is a whole host more work to be done, particularly now as integrated teams, either in mental health or in general care, such as the virtual ward, are becoming the norm. There is a challenge about sorting out that regulatory framework.

11:00

[193] If I could comment very briefly on care homes, because it touches on HIW and CSSIW, in our experience now there are some complex patients who are cared for in care homes. CSSIW is the main regulator, but healthcare is provided within those settings by registered nurses and others. Again, I think that there is a need to try to bring them together to ensure that there are no gaps in regulation in that sector. Again, health boards have clear commissioning responsibility for quality and safety around that, but the regulatory system seems to be just a little behind where we are. So, we need firming up around that. Shall I leave the WAO/HIW to you?

[194] **Dr Goodall:** On the joint working in general terms, I would just like to distinguish what is the beat and the pace of just the normal, annual mechanism for us to take assurance, as opposed to what is the risk assessment where you would perhaps want us to target things. If the auditor general has been saying that it would really need to be targeted at risk, I would agree with that in part, because I think that that would be the benefit of bringing that joint resource to the table, but as I have tried to advocate through the last 40 minutes or so, I would like to see a strengthening of just the annual machinery for us to have a very broad assurance, not least because it allows my own board to have an external perspective on how well we are doing, or not, and where we need to improve. If we are going to pursue the Betsi-type experience then, and if that was to be done everywhere, I would rather see it through risk eyes.

[195] I am interested, however, in promoting the good news that I know that regulators and inspectors are working together. They have their annual summits and have very regular contact with each other. The bit that I would really want to ask about is this: although they are

sharing that with each other, it does not necessarily mean that I know what the discussion has been about Aneurin Bevan health board, and which are the areas of concern as they bring together their respective experiences—the things that they would expect to be progressed through my own board, or perhaps there would be a governance concern that would need to picked up. So, although there may be an annual summit among the regulators, it does need to be translated into something that says to the board, 'Here are areas of concern that may need to be targeted', and that might be part of that risk-based approach that you are outlining from the auditor general.

[196] I think that there is another aspect to offer the regulators, however—that they must have the chance to help boards to discharge their own governance and assurance, both with the Wales Audit Office and Healthcare Inspectorate Wales. We have done it jointly with other regulators as well—my board members have had an opportunity not just to have a discussion with executives in the room, but to have quite a frank and free discussion with the regulators in their independent member roles to make sure that anything that they are picking up can be shared, but equally, for them to have a pretty straight view of how we are acting as an organisation. A combination of those types of approaches would definitely work for us to discharge our own responsibility to improve services and to make them safe.

[197] **David Rees:** Are there any other questions from Members? We have two minutes. There are no further questions.

[198] I thank Andrew Goodall and Carol Shillabeer for coming this morning to give evidence. I very much appreciate it. You will receive a copy of the transcript for factual correction purposes. Thank you once again for representing not just the health boards—obviously, you have represented your own health boards—but the NHS on a wider basis.

[199] I now propose that we have a 10-minute break before we recommence at 11.15 a.m.

Gorhiriwyd y cyfarfod rhwng 11:03 a 11:15.
The meeting adjourned between 11:03 and 11:15.

Ymchwiliad i Waith Arolygiaeth Gofal Iechyd Cymru: Panel 3—Bwrdd Cynghorau Iechyd Cymuned Cymru a Chymdeithas y Cleifion
Inquiry into the Work of Healthcare Inspectorate Wales: Panel 3—Board of Community Health Councils in Wales and Patients Association

[200] **David Rees:** Welcome back to this morning's session on the inquiry into the work of Healthcare Inspectorate Wales. On the third panel, we have Cathy O'Sullivan, the acting director of the Board of Community Health Councils, and Katherine Murphy, the chief executive of the Patients Association. Good morning and welcome. Thank you for your written submissions to the inquiry. Given that we have half an hour today, we will move straight to the questions from Members, if that is okay. Gwyn, do you want to start?

[201] **Gwyn R. Price:** Yes. Good morning to you both. What is the Patients Association in Wales's view on the question of whether HIW has sufficient capacity to deliver its core functions?

[202] **Ms O'Sullivan:** From the Board of Community Health Councils in Wales's point of view, the answer is 'no, I don't'. In our experience across Wales, there is a very dedicated team that is really keen to get the work done, but there are gaps within the organisation in relation to managing the intelligence that can be generated across Wales and then utilising that appropriately. So, no, I do not believe that it has the capacity right now.

[203] **Gwyn R. Price:** Katherine, do you have a view on that?

[204] **Ms Murphy:** From the evidence and the knowledge that we have of Healthcare Inspectorate Wales, we would say that it is under-resourced. To echo what Cathy has just said, there is a huge gap in the way that it collects intelligence from patients and members of the public, which is vital for the delivery of its work.

[205] **Gwyn R. Price:** I notice that you used the example of the helpline to emphasise the point that there is a shortfall in understanding what happens there.

[206] **Ms Murphy:** Yes, absolutely. The Patients Association is a national independent health and social care charity, and all of our work and the evidence that we collect comes from our national helpline. During 2012, we received 900 calls from patients and members of the public in Wales. That was up by about 140 calls compared with the previous year. So, there is a desperate need in Wales for patients and the public to have an avenue through which they can express its concerns and to know that those concerns will lead to the action that is necessary.

[207] **David Rees:** Lindsay, do you have a supplementary question?

[208] **Lindsay Whittle:** Yes, on that issue. Are most patients aware of Healthcare Inspectorate Wales? Is that your experience? I would not have thought so.

[209] **Ms Murphy:** Once again, from the evidence that we have at the Patients Association, the public is not aware of Healthcare Inspectorate Wales. The vast majority of the public in Wales is not aware of Healthcare Inspectorate Wales and most are not aware of the remit and role of Healthcare Inspectorate Wales. For an organisation that is supposed to be supporting patients and the public, it is vital for it to be much better known among the public.

[210] **Lindsay Whittle:** Should it be more proactive in its work? For example, when you are first admitted to hospital, should you be given—and I do not know whether you are given this, as I have not been hospital for a long time now—a leaflet saying, ‘If you have problems, these are the people to contact’?

[211] **Ms Murphy:** Yes, absolutely. Patients should be given information so that if they have a concern, they know who to go to. If they have a good experience, Healthcare Inspectorate Wales also needs to have a function to collect evidence of good practice and be the catalyst for the sharing of good practice within hospitals, trusts and GP practices in Wales.

[212] **Lindsay Whittle:** Thank you for that reply, because this is important.

[213] **David Rees:** Cathy, do you want to come in on that point?

[214] **Ms O’Sullivan:** Yes. There is a slight misunderstanding of the roles. Community health councils have that role, and all patients who go in to hospital will have access to the contacts for CHCs. Concerns, grievances or expressions of contentment with the service can be delivered through the CHC, and we will support people either to pursue an inquiry about a concern that they might have or to reconcile any differences with the NHS. HIW does not actually provide that level of support. That is provided through community health councils.

[215] **David Rees:** Kirsty, do you want to come in on this? You have the next question in any case.

[216] **Kirsty Williams:** I will ask that now then. The Patients Association paper is quite damning in what it states about HIW. I quote:

[217] ‘In seeking to respond to this question we have tried to investigate the regulatory actions taken by HIW in recent years but this has proven to be impossible as the information simply does not appear to be available in a form which enables conclusions on effectiveness to be reached.’

[218] We appreciate that there might be issues around lack of clarity of role and purpose, and issues around capacity, but as organisations that are concerned in this field, would the CHC agree with the Patients Association that it is difficult to make a judgment on how effectively HIW currently carries out its roles and functions?

[219] **Ms O’Sullivan:** From a lay perspective and from the patient perspective, yes, it is difficult. I would not be as damning, because I believe that the information is there. However, I do not believe that it has actually been collated in such a way that makes access easy to that.

[220] **Kirsty Williams:** In the view of the Patients Association, what could HIW do, or what should we recommend to the Minister that is done, to ensure that, in future, we can be clearer about establishing whether the organisation is effective in carrying out its role? What could we recommend?

[221] **Ms Murphy:** I think that HIW needs to liaise with organisations like the board of CHCs, and there are many other third sector organisations in Wales that it needs to work more closely with in gathering evidence. It also needs to be actively speaking to patients and the public.

[222] **David Rees:** Do you have a question, William?

[223] **William Graham:** Yes, thank you. Do you think that you would share the concerns of the health board that having the two separate organisations is not over-helpful?

[224] **Ms O’Sullivan:** Do you mean in relation to inspections?

[225] **William Graham:** Yes.

[226] **Ms O’Sullivan:** I actually think that the patients’ view of the services that they receive is paramount, and it needs to be independently obtained. I think that what we do not do well, and we should do better, is actually work together. CHCs have the ability to act with immediacy. If we receive a significant concern around poor-quality delivery, we can get teams out almost immediately across Wales. Within two hours we can have a team on the ward. HIW cannot respond in that way, but it needs to utilise us to support and augment the work that it is doing. There are many options here for future delivery and joint working. I do not think that we compete with each other; I think that we should complement each other. Greater progress needs to be made to do just that.

[227] **William Graham:** On a slightly different issue—

[228] **David Rees:** We will come back to that, William, because Rebecca has a question on this.

[229] **Rebecca Evans:** There is a memorandum of understanding between CHCs and HIW. I wonder whether you feel that that is fit for purpose or whether it should be amended to reflect the concerns that you have just raised.

[230] **Ms O’Sullivan:** Thankfully, the new chief executive is actually working with me at the moment to redo that memorandum of understanding, but that is just a policy document.

We have decided that we will get much more benefit from a working protocol so that we can establish greater avenues for information-sharing, for handling the intelligence that CHCs can provide, and then HIW acting more effectively on that. I am delighted that that approach now is virtually near completion.

[231] **Rebecca Evans:** Would that working protocol include visits? We heard from our previous witnesses from the health boards that there seemed to be a lack of co-ordination in terms of visits. You might have a CHC visiting one day and then HIW visiting the next day, for example. To go along with that, do you think that you can work more closely together while still retaining your independence, which is very important?

[232] **Ms O'Sullivan:** As long as we maintain our independence we can work very closely together; there is no bar to that at all. However, we have had the concordat in Wales, which has not been that successful. Work is under way now to redeliver that level of co-ordination and information-sharing through that route. I am not sure that HIW carries out visits as regularly as we do. We are probably in a hospital every week; I do not think that HIW is able to sustain that level of delivery. There have been very few occasions that I am aware of where we have gone in one day and HIW has been in the next. We may have different views, but that is right and reasonable in relation to what we find from the patient perspective. We are talking about what patients feel and what laypeople feel about the quality of those services, rather than the professional view. Those two should come together.

[233] **Rebecca Evans:** Finally, with regard to the protocol, do you have a timescale as to when that might be agreed?

[234] **Ms O'Sullivan:** I am putting it to the board on 4 November, and we should be in a position to sign it off at that point.

[235] **Rebecca Evans:** Lovely, thank you.

[236] **David Rees:** I have two supplementary questions from Lynne and Kirsty, and then we will go back to William.

[237] **Lynne Neagle:** I just want to better understand the liaison between the CHCs and Healthcare Inspectorate Wales. Say that the CHCs go into a hospital and they find things that they are worried about, do they automatically notify HIW then? What is the communication like in that area?

[238] **Ms O'Sullivan:** I think that it has been patchy across CHCs in Wales, in all honesty. However, some CHCs do diligently send reports where they have significant concerns. Certainly, some CHCs send quarterly reports of all their findings and then the responses and the action plans that they have agreed with the health boards to pursue some of those areas and make sure that they are delivered. We also send quarterly reports to HIW on the trends in complaints and enquiries.

[239] **Lynne Neagle:** Have there been any examples where CHCs have gone in and found things that were really very worrying and then notified HIW and then rode to the rescue? Has that ever happened?

[240] **Ms O'Sullivan:** No.

[241] **Kirsty Williams:** You have said that there is no formal process by which CHC members would report concerns to HIW and you have said that some CHCs do it. How many is 'some'? On a regular basis, how many CHCs in Wales are proactively reporting their findings back, good or bad, to HIW?

[242] **Ms O'Sullivan:** I believe that it is three.

[243] **Kirsty Williams:** Three. There have been concordats, memoranda of understanding and protocols et cetera for a number of years and, clearly, they have not worked, otherwise you would not be redoing them at the moment. Why is this time going to be different? What is going to be different about your new protocol as opposed to previous documents that have obviously not delivered?

[244] **Ms O'Sullivan:** I think that that is a reasonable question. I think that it is the desire to actually act on it. We have a strategic board for Wales now, which is staggeringly impressive in the way that it has shifted how it will be working for the future over the last four months. I cannot answer for the previous board and director. I have been in post for four months, and I have seen massive changes in relation to how the board wants to work with other organisations and ensure consistent standards across Wales. So, it is setting the standards and the direction for all CHCs to follow.

[245] **Kirsty Williams:** If, in future, a CHC goes into a hospital or a care setting and witnesses the inappropriate care that Lynne Neagle just outlined and fails to report back to HIW, do you not feel that it is culpable for allowing that poor care to continue?

[246] **Ms O'Sullivan:** Yes, I would. It is our responsibility to do just that.

[247] **David Rees:** Darren, you have a supplementary question on this point, and then I want to go back to William.

[248] **Darren Millar:** There has been lots of concern raised about the transparency and the availability of HIW reports. You refer in your evidence to the fact that HIW reports are not always shared with CHCs. Sometimes, the first that you know about them is something that pops up in the media, which is clearly unacceptable. However, who do you share your reports with as CHCs? Are they circulated to the public in the public domain?

[249] **Ms O'Sullivan:** Yes. We go through a process of enabling the health boards or the NHS organisations to respond and provide us with an action plan on how they are going to address the issues of concern, and that does go into the public domain. So, they would be on the websites and so will the trended report on the care levels—

[250] **Darren Millar:** But HIW will tell us, 'These are available on our website, and the public should track them down. It might take half an hour to find the right one in relation to your local hospital, but it's there, it's in the public domain, and we don't need to do anything else.'

11:30

[251] **Ms O'Sullivan:** We are fortunate that we have an escalation process. If we cannot get traction on any information that we send to the health boards or NHS organisations and we cannot get the changes that we require, we can then move that through HIW and also take it to the director general, if we feel that the health boards are not complying with what is required for patient safety or patient quality. The ultimate point of contact for us then would be the Minister. However, we would avoid that; we would like to get that through the proper operational protocols within the NHS.

[252] **Darren Millar:** However, are you not guilty as CHCs of the same criticisms that you are laying at HIW's feet, in terms of the transparency and availability of information, particularly to patients? How would a patient in north or west Wales, or wherever they might

be, be able to know what that escalation process is, where their local hospital is at in relation to the escalation process that you as CHCs have?

[253] **Ms O'Sullivan:** Patients probably would not want to know what the escalation process is.

[254] **Darren Millar:** I am sure that they would want to know if a problem has been identified; of course they would.

[255] **Ms O'Sullivan:** I do not know. If a problem has been identified, they would like to know that it has been resolved rather than the process that you used to get it resolved. People are more interested in the resolution and having the quality improve rather than the mechanism by which you get there.

[256] **Darren Millar:** However, they would like to know if there has been a failure to improve and that things are being escalated so that there are better monitoring arrangements, or whatever else might emerge as a result.

[257] **Ms O'Sullivan:** Hence our holding public meetings. We have meetings in public that all people who are interested can attend. All of the papers and information for those will be available—and readily available.

[258] **Darren Millar:** Health boards have public meetings, of course, but there is often criticism about the accessibility of the papers that are put into the public domain on their websites.

[259] **Ms O'Sullivan:** They hold meetings in public; we, on our agenda, specifically provide access to the public to come to talk to us and tell us what their concerns are, or whatever they wish to do. So, it is a different set-up in relation to the meetings in public for an NHS organisation and a CHC organisation.

[260] **David Rees:** May I confirm, therefore, that all of the papers and reports that you produce on those issues are part and parcel of those public meetings?

[261] **Ms O'Sullivan:** They are, yes. Nothing is held back. We work transparently with the public.

[262] **David Rees:** Okay, we will move on and go back to William.

[263] **William Graham:** We heard this morning in evidence from the Wales Audit Office that it was concerned about the retention of staff at HIW and, in the other submission, regarding the increasing use of external advisers in terms of their validation. Has this been your experience?

[264] **Ms O'Sullivan:** Not really, no, but there again, I would not have been involved in the details around what staff they would need to call in for any investigation, specific or otherwise.

[265] **Ms Murphy:** I do not feel in a position to be able to comment on that in relation to Wales. However, I would say that it is really important that HIW has the right staff and skills, and continuity of service is important to deliver the safe, high-quality service that is needed for patients.

[266] **David Rees:** Rebecca, do you have a question?

[267] **Rebecca Evans:** No.

[268] **David Rees:** It has been asked.

[269] In relation to the memorandum that you are putting together and the protocols, you mentioned earlier that you were not getting reports from HIW that easily. Is that part and parcel of the new protocols that you have put in place?

[270] **Ms O'Sullivan:** Yes, it is.

[271] **David Rees:** Therefore, there should now be no excuse regarding why you are not getting those reports.

[272] **Ms O'Sullivan:** No.

[273] **Lynne Neagle:** We have had some discussion this morning about whether we should recommend changing the current system to give HIW more formal autonomy. Do you have any views on the way in which things operate at the moment? In particular, it has to have discussions with the Minister before placing any service into special measures.

[274] **Ms Murphy:** Personally, and on behalf of the Patients Association, we believe that Healthcare Inspectorate Wales should be completely independent and have the autonomy to be able to deal with whatever comes its way within its remit.

[275] **Ms O'Sullivan:** I would just offer a caveat to that that there needs to be a level of scruitny of what HIW is achieving, in the same way that there needs to be a level of scrutiny in what CHCs are achieving.

[276] **Kirsty Williams:** Lynne mentioned the issue of special measures; what is the CHCs' understanding of the escalation process that may exist within HIW and Welsh Government, and what is your understanding of what constitutes 'special measures'?

[277] **Ms O'Sullivan:** I am sorry; I cannot offer anything on that. I have no collective view in relation to how escalation processes happen within HIW.

[278] **Kirsty Williams:** Do you think that, as CHCs, you should have clarity as to how escalation occurs within HIW, what constitutes a service in special measures and what happens as a result of special measures?

[279] **Ms O'Sullivan:** Absolutely.

[280] **Kirsty Williams:** However, you do not have that clarity at the moment.

[281] **Ms O'Sullivan:** No, we do not.

[282] **Elin Jones:** Do you have a view on the number of inspections that HIW undertakes in a year? I was struck yesterday, when I looked at the inspection regulation reports by HIW on its website, how few reports there are based on hospitals. I could find only one report relating to Bronglais hospital, and that was for a particular ward. It struck me that that was very little. Do you think that there is a need to scale up the number of hospital inspections that HIW does? On another issue, namely the inspection work between HIW and CSSIW on integrated care, care in the community, care in homes—the healthcare now being developed and delivered in homes—how much of a danger is there that that element of care could fall through the gap and not be inspected? Do you have concerns about that? Finally, Leighton raised an issue earlier about inspections of GP practices. Do CHCs inspect GP practices?

[283] **Ms O'Sullivan:** Yes, we do. To take your first point, around increasing inspections by HIW, with its current capacity, I am not sure that that could be achieved. It would need to increase its capacity considerably. However, there is great scope here for inter-agency working and inter-organisation working. Why not utilise the evidence that we provide in relation to our very regular contact with wards, departments, GP premises, opticians and pharmacies? You name it and we are out there, day in and day out, doing this work. I am more than happy to put a mechanism in place through the board so that we can have some consistency of approach across Wales to deliver that information to HIW. It is about utilising what we currently have, rather than reinventing and increasing capacities that perhaps may not be needed.

[284] In relation to health and social care, it is a real concern to us how we are going to monitor the services delivered in people's own homes. There is an enormous shift out there and a great interface between health and social care delivery. Patients do not necessarily care who is paying out of which pot. What they care about is that they are getting something for their needs. It is not always easy to extrapolate healthcare from social care. Health and social services have been having this problem for years. We are still going through arguments on this. What we should be monitoring is service delivery, but doing that in an independent way. CHCs are constrained; we cannot visit individual homes, but we can be more creative around ensuring that the the voices of patients and carers are independently elicited and come back to us for independent assessment. Then, we can offer that information back to the NHS, HIW and Welsh Government.

[285] **David Rees:** We have a little time left and I have three people who want to ask questions.

[286] **Lynne Neagle:** Does HIW consult with you about its forward work programme, not just if there is a concern that comes to light, but in general when it is doing thematic reviews? How does it take the patient voice into consideration in drawing up its forward work programme?

[287] **Ms O'Sullivan:** I believe that it has consulted in the past on its forward work programmes. However, consulting with CHCs is not consulting and eliciting the view of patients and the public. There is a considerable amount of work to be done if it is to get the patient view on some of these thematic reviews. We have seen some attempts in the past, and health boards are working towards delivering that with HIW. However, a level of independence is needed in this. It is not appropriate for those who regulate and deliver to go out to have that conversation with patients. Why not utilise CHCs? We are willing and able, and the opportunity is there.

[288] **Rebecca Evans:** We heard from the health boards this morning, and we have had it in written evidence, about some concerns that, when HIW reports come out, there is a time lag; essentially, they are quite out of date. Is this a problem for patients who might be relying on out-of-date information or are concerned about problems that have already been addressed?

[289] **Ms O'Sullivan:** If you have a patient who has gone through a service where they feel that the quality of that service was detrimental to them, HIW does a review, an investigation or even just an inspection. Then, you wait a year for that report to come out. That no longer resonates with the individuals concerned. People need to see speedy outcomes—certainly speedier outcomes than are currently seen. I am not sure that it even resonates with the NHS when those reports come out. There has to be a much more truncated approach to getting this work done.

[290] **Ms Murphy:** I echo what Cathy has just said. Obviously, if it inspects, HIW needs to be efficient and effective in what it is doing. Publishing a report a year later is no consolation for a member of the public who has had a poor experience. So, the report needs to be topical and carried out as quickly as possible and necessary actions need to be addressed.

[291] **David Rees:** As part of your protocols, do you have time limits on those reports coming back to the CHCs so that they are appropriate?

[292] **Ms O'Sullivan:** No. That would not fall into the protocol between CHCs and HIW, but we have requested that. I recognise that HIW is suffering from resource and capacity issues. Under the circumstances, it will not be easy for it to deliver. I am fully aware of the drive and determination that has been portrayed so far by the new chief executive to get to grips with this area of difficulty that it has been having for quite a few years.

[293] **David Rees:** We have two more questions, from Darren and then Kirsty.

[294] **Darren Millar:** Very briefly, my question is in reference to your submission as the Patients Association, Katherine. You make reference to the potential to redefine HIW's website to make it more accessible to patients, so that they can determine the quality of care in their local hospital or whichever other setting may have been inspected. Can you tell us a little about that and whether there are good examples that you might be aware of?

[295] **Ms Murphy:** The Care Quality Commission website is a very effective website. HIW, as an organisation that is there to regulate and inspect and as an assurance point for patients and the public, needs to be accessible to patients and the public. Its current website is more for healthcare professionals than it is for any patient or member of the public. I spent some time on the website and I found it difficult. If you are looking for a report on a particular hospital or on a particular area, it is almost impossible to find anything. It needs to be easy for the public to access the information that they need at that given time. However, the Care Quality Commission website encourages patients to give feedback. The HIW website does not encourage any feedback or information from patients and the public, or from other third sector organisations, or any organisation that is providing services—it does not ask for that.

[296] **Darren Millar:** I saw that you were nodding, Cathy.

[297] **Ms O'Sullivan:** To some of it, yes. England has a different structure—it no longer has CHCs—so it needs a Care Quality Commission that, perhaps, is more encompassing than it would be in Wales.

11:45

[298] I would expect to see a direct link for patients to offer their concerns to us, and that we, as the independent body, could feed that to where it needs to be. I am not sure that what we want is duplication of what is already happening in relation to patients and the public contacting the CHC. We need to make sure that that information exchange is appropriate and reasonable.

[299] **Darren Millar:** I am sorry; I do not quite understand this. If I am a patient and I want to know what the quality of care is like in my local hospital, at the moment I might have to trawl through the HIW website to see a certain aspect of care that it has reported on. I have just looked at one of the CHC websites and it is almost impossible to find a specific reference, which is easy to navigate, to specific local hospital issues, without going through the agenda of each CHC and looking through the hundreds and hundreds of pages to see what those reports have said. Therefore, are you saying that you disagree with the Patients Association,

Cathy, when it suggests that that information ought to be more accessible and easily available to the public, so that it can see directly what the standard of care is in a local hospital?

[300] **Ms O'Sullivan:** My apologies for not making myself clear. I agree with that aspect about having that information upfront and accessible. What I do not agree with is that the CHC should be circumnavigated in this process, of patients' concerns being offered to HIW and the CHC. We will get an awful lot of duplication of the same concern and inflated numbers. What we need is actual numbers and action that can be taken against those numbers, and we need to utilise what we already have for some aspects of that, but I am very much in agreement with the Patients Association about making the site more accessible and about what matters to people.

[301] **Darren Millar:** In your—

[302] **David Rees:** We have very little time.

[303] **Darren Millar:** I appreciate that.

[304] **David Rees:** You may ask a last question, then Kirsty has a question, and that is it.

[305] **Darren Millar:** I just want to pursue this a little more. In your evidence to the committee, you say that you are disappointed that HIW does not pay attention to patient concerns. Yet, you are now telling us, 'It should not; that is our job'.

[306] **Ms O'Sullivan:** No. What I said is that it does not offer an appropriate referral, in my evidence, that it—

[307] **Darren Millar:** No, you did not. You said that it was lacking in meaningful engagement with patients and that you would like to see more of it.

[308] **Ms O'Sullivan:** I was referring to meaningful engagement with patients in relation to the work that it undertakes. If it is doing a mental health review, how many patients is it talking to? How many service users is it eliciting the views from? If it is going to go out and do an inspection on a particular service delivery—stroke pathways or coronary heart disease—how many service users does it actually build into that process when it is doing that review? Is it listening to the patient's voice when it undertakes those exercises?

[309] **Darren Millar:** You were then suggesting, in response to what Katherine said—

[310] **David Rees:** You—

[311] **Darren Millar:** I am terribly sorry, but I just need to understand this. You were then suggesting that it should not ask for patient feedback on its reports on its own website, because that is your job.

[312] **Ms O'Sullivan:** No, I was not quite suggesting that.

[313] **Darren Millar:** You did suggest that.

[314] **Ms O'Sullivan:** What I was suggesting was that we are there to help and support patients and we can handle their concerns. It does not have a role, currently, in tackling individual concerns. I would not have a problem with registering those concerns, as long as the information is co-ordinated and we are not duplicating effort.

[315] **David Rees:** The point has been made. Kirsty is next.

[316] **Kirsty Williams:** To add to that, by your own admission, you do not send all the information that you have to HIW. So, I appreciate that you do not want duplication, but when you turn around and tell us that only three of your CHCs send regular reports of their findings to HIW, that rings alarm bells with me.

[317] However, I will come to my final question. The motivation behind this committee carrying out this piece of work was that, in the light of the Francis report, we wanted to satisfy ourselves that we had an inspection and regulation regime in Wales that was fit for purpose. As it is currently constituted, are you both of the belief that if we had a Mid Staffordshire NHS Foundation Trust situation developing in a Welsh hospital, we would have an early warning system that would alert us to that to allow us to take action? Do we have that system?

[318] **Ms O'Sullivan:** I think that we have the makings of that system.

[319] **Ms Murphy:** I would like to feel confident that that system is in place, but I cannot assure you that it is.

[320] **David Rees:** I think that that is the answer that we wanted. Thank you very much for your evidence. Time has passed us by. You will receive a transcript of the evidence session today for factual correction purposes. Once again, thank you to Cathy O'Sullivan and Katherine Murphy for coming today.

11:49

Ymchwiliad i Waith Arolygiaeth Gofal Iechyd Cymru: Panel 4—Cymdeithas Gofal Iechyd Annibynnol Cymru
Inquiry into the Work of Healthcare Inspectorate Wales: Panel 4—Welsh Independent Healthcare Association

[321] **David Rees:** We move on to the next item with the last panel of witnesses this morning—

[322] **Elin Jones:** May I just ask a question? On the information that comes to us as a committee, Healthcare Inspectorate Wales will come at some point—

[323] **David Rees:** In three weeks' time.

[324] **Elin Jones:** I think it would be useful for us to have a full briefing in advance of that on the make-up of, and an analysis of, Healthcare Inspectorate Wales's work over the last five years. I looked at its website yesterday and it is difficult to find, and to profile, the work that it has been doing. We cannot expect Healthcare Inspectorate Wales to provide us with that. I think we should have an independent briefing from the Research Service on the set-up and the work profile, and its forward work programme as well, which is referred to in the Research Service briefing, but which we have not seen, unless we have found it ourselves.

[325] **David Rees:** Yes, we will get that organised.

[326] **Kirsty Williams:** I will tell you what I would like as well: I would like to see, when they have done a report, what the follow-up is. So, is there any evidence, having carried out something, about how they follow that up?

[327] **David Rees:** I am sure that we can ask them those questions as well.

[328] **Lynne Neagle:** Can we have some case studies in advance? That would be useful, would it not? Some case studies where HIW has gone in, and what it has done afterwards.

[329] **David Rees:** We are still in public session.

[330] **Lynne Neagle:** Sorry.

[331] **David Rees:** The Research Service will have listened to your views.

[332] I welcome, for the final session this morning, Nicola Amery, who is chair of the Welsh Independent Healthcare Association; Steve Bartley, the former deputy chair of the association; and Karen Healey, who is chair of the association's senior nurse group. Thank you very much for coming this morning, and thank you for your written evidence. I just remind Members that we have listened to witness evidence from public sector bodies this morning, but we have now the independent sector, for which Healthcare Inspectorate Wales is also responsible. Do you wish to perhaps give a brief opening statement before we go into questions?

[333] **Ms Amery:** On behalf of all of us, really, we welcome the opportunity to be involved in giving some feedback. Obviously, the independent sector is regulated by HIW and, as such, it is very much our guiding force behind setting standards and doing what we do in the independent sector. It is good to have the opportunity to give some feedback. I know we have given a written response, and I think that there are probably a couple of themes that come from that that would be worth bringing out. By and large, we are pretty supportive of what HIW does, and the difficult job it has to do. It is very clear to us from the independent sector that there have been some resource issues that have shaped and constrained its inspection and registration teams in the last few years. It is not recent, either—certainly in the last five or six years, that has definitely been a factor in the way that it has approached its work. In general terms, on the acute side, we have had very good working relationships with the inspectors. That has been less the case in mental health in the last few years. The resource issues have really been the thing that appear to have shaped and coloured the performance of HIW in the last few years, so, things like delayed reports, stuff not going up onto the website, delays in responses and, in some cases, certainly in mental health, sometimes inappropriate inspectors coming in with inappropriate experience, or lack of experience, to complete the inspection process. We have always tried to remain open in our approaches with Healthcare Inspectorate Wales, and to collaborate in whatever way we can to help the inspection and registration process run as smoothly as possible. Although none of us really want to go through an inspection process, at provider level we all recognise the importance of that in order to maintain the robustness of the standards.

[334] **David Rees:** Thank you very much for that. Lindsay has the first question.

[335] **Lindsay Whittle:** Thank you very much for that evidence. I am delighted that you said that not one of us likes anyone inspecting us; it is really quite stressful, and we have all gone through it in our working lives, but of course it is extremely necessary. In your evidence to us, you talk about the inspection reports coming back to you and the delay in those reports. The timescale is really quite unacceptably long, and that is evidence that we have heard before this morning—it seems to be consistent evidence—which is extremely worrying. How often is this happening in your particular field, please? What improvements would you suggest that we need to be suggesting to ensure that this does not happen in the future?

[336] **Ms Amery:** Certainly from the acute sector, in the last five years, let us say, Healthcare Inspectorate Wales has, by and large, continued to do an annual inspection with the exception of the last 12 to 18 months. Invariably, our inspection reports do not come to us

for two months, three months, six months and, for the last inspection that we had—in fact, our last inspection was in January 2012—we did not get a report at all. We finally had a visitation from the senior executives at HIW, and we had a final letter a year and a bit after the inspection. We had some verbal feedback at the time of the inspection, so we were reasonably confident that there would not be any surprises in the written report, but there were some inaccuracies even when the letter came through to us, and that makes it very difficult then to follow through and make sure that we are working on the right things that HIW wants to focus on. I think that that has been consistent, not just for my hospital, but for other hospitals, too, both in the acute and the mental health fields.

[337] **Ms Healey:** I would just say that I work in the acute sector as well, and in the inspections that we went through in commissioning two new builds in Wales, HIW was very engaged with us when we opened the facilities in 2008 and 2010. In fact, we worked in partnership, because we had 15 inspectors per day inspecting and learning from the environment of commissioning two new builds, because that had not happened in Wales in the independent sector for such a long time. We welcomed that partnership approach, but, as Nicky has said, we have had two unannounced inspections since we commissioned in 2008. When we had the last inspection, we waited 17 months for our report. The inspectors came back out a year later to revalidate—the issue seemed to be with the quality assurance process. The report that we have received contained unprecedented compliments and no recommendations, but having said that, that report, received in March, is still not available on the web page for the public to view and for us to be able to demonstrate the quality of our standards. So, although we understand the pressures of the inspection process, it is concerning that we are still without that publication on the inspection site at this point in time.

[338] **Lindsay Whittle:** Well, I think that that blows public confidence out of the water, quite frankly. That statement today is amazing. If I want to see which is the best service provider, I do not want it to take 17 to 20 months. The report could be a glowing one, which you mentioned, and that is great, but what if the report is not a glowing one? That is extremely worrying. Thank you so much for that evidence.

[339] **David Rees:** Kirsty wants to follow up on that point.

[340] **Kirsty Williams:** I am just wondering about the field of mental health, because some people might argue that, in acute private medicine, people are opting into that system for a whole variety of reasons, but, actually, in the mental health system, many of the services are actually commissioned by the NHS because the NHS itself is unable to provide them.

[341] **Mr Bartley:** I think that about 99% of the mental health services are actually commissioned by the NHS, and the reporting is exactly the same, to be perfectly frank. It takes a very long time to see the reports, and there has been a significant shift in the type of report over the past few years. I think that part of that—which is something that we understand—is because of the resource pressures that HIW had in terms of producing full reports.

[342] Certainly, some years back, the reports were very full reports, with the positives highlighted and the negatives highlighted—absolutely, the negatives need to be highlighted. However, our last reports have very much changed from a report to a management letter. So, we get simply one or two pages, which are a list, really, of the things that we need to improve. Now, there is quite a significant difference, I think, between the reports and the management letters that those on the acute side see, against the mental health ones, because, certainly, in the mental health field, we have more areas that need some concern, and part of that is perhaps the nature of the beast, to some extent. So, certainly in the mental health field, we very much see the reports as being a series of negatives, which actually leaves us, in some ways, often feeling very vulnerable. The staff see the inspectors come in, they are often there

for two to three days, and they spend a lot of time with them, engaged with the inspectors, and then to find that nothing positive has been said leaves people feeling, I would say, quite angry.

[343] **David Rees:** Karen, did you want to come back in?

[344] **Ms Healey:** I just want to clarify and support Steve in what he is saying. What we have seen in the independent sector is a problem, particularly in the last 18 months to two years, whereas, before that, the reports that came out were detailed and there were very good relationships.

12:00

[345] We still have very good relationships with HIW, but there appears to be a delay in the quality-assurance process of HIW in validating the reports. The inspectors that are coming out are not as experienced as we would hope for them to be in the areas that they are inspecting, whereas previously there appeared to be a very robust framework. Whatever has changed appears to have changed in the last 18 months from our viewpoint.

[346] **Kirsty Williams:** Having been in receipt of the report, or more latterly, in receipt of your management letter outlining what you need to improve, could you outline to us the process that HIW goes through to ensure that, as providers of services, you are enacting the contents of that management letter?

[347] **Mr Bartley:** The essential part is that, at the end of each inspection, we sit down with the inspectors. In fairness, we get quite detailed feedback, and we start our action from that point. One reason for that is because the management letters are often somewhat late. More recently, in the last few months, we had one inspection in July and we had the management letter within weeks. So, the management letters have come much faster, but that is just one example. However, in terms of the actions, it is incumbent on the provider to provide an action plan to the inspectors, and they would take that into their QA process and follow it up, generally at the next inspection whenever that might be, but that could be a considerable time away. I know of one particular hospital where the last inspection was in October 2011.

[348] **Kirsty Williams:** Okay. So, the proactive follow-up to make sure that you are doing what you are supposed to be doing could be at the next inspection, rather than anything that is ongoing?

[349] **Mr Bartley:** It is incumbent on us to feed back to the inspectors to say that we believe that we have met our standard in compliance with the regulation.

[350] **David Rees:** Rebecca has a question on this as well.

[351] **Rebecca Evans:** My point relates to observations on mental health. We have had a paper from the Wales Audit Office saying that a prominent feature of HIW's work is in the field of mental health, and that HIW has built up expertise that should be used more explicitly to help secure the continued development of safe and effective mental health services in Wales. That does not seem to sit very well with the evidence that you have just given.

[352] **Mr Bartley:** I find that slightly strange. I have worked within the sector and with HIW; I am the responsible individual for the group, and have been since 2006. Throughout that time, there have been only a couple of inspectors. Over the last four or five years, there has been just one lead inspector in mental health, who is now the head of regulation and so is technically not an inspector at this point. I believe that someone else has been recruited. The other people we see are lay inspectors who are brought in, and there is a range of those. They

are often people who do not have experience necessarily in mental health. Within the independent sector in particular, we are generally seeing people with very complex mental health needs. If they were less complex needs, the NHS would be dealing with them, and we only see people whom the NHS primarily cannot or will not work with.

[353] Quite often, we have to spend a lot of time with inspectors to make sure that they are safe, because their approach to a person is often based on how you might approach a person in the public arena. This is where we are dealing with people with complex forensic histories, very complex personality disorders or autistic spectrum disorders, where people do not understand or recognise the social parameters. So, we spend a lot of time trying to work with inspectors in making sure that they are safe and that our clients can communicate with them. I find it difficult to see where that level of expertise is. There is a level of expertise in that there is at least one very experienced inspector. We had a number of inspections from the acute inspector—Philomena—who is a very able inspector and who is very cognisant of people with mental health disorders. Beyond that, I would have to say that I am surprised.

[354] **Rebecca Evans:** We have been told that the reason why HIW employs this model of having a small core staff, and then accesses wider expertise, is precisely so that it can send the people with the right skills to do the inspections.

[355] **Mr Bartley:** I can see the rationale in that. I can remember only one inspection over the years where we actually had a psychologist—she was a very able psychologist—but she has not been with them for the last couple of years. Certainly, I know that, about 18 months ago—certainly within the last two years—I think that HIW reviewed its panel of lay inspectors and dramatically shortened it. Some colleagues that I work closely with were previously inspectors—very experienced mental health practitioners—but they are no longer on the panels.

[356] **David Rees:** Okay. I have questions from Gwyn, William, Lynne, Darren and Leighton. I have a long sequence.

[357] **Gwyn R. Price:** Good morning to you—perhaps it is afternoon now. Can you tell me the extent to which your members currently participate in self-assessment? What are the strengths and weaknesses of this approach?

[358] **Ms Amery:** That is a very interesting question, because we no longer do self-assessment. Back in 2009, I think, we started a process of piloting some self-assessment tools in conjunction with HIW, and a lot of effort was put into that. It was announced with a degree of fanfare, saying, 'This is the way to work in the future', which is fine. It enabled us to send information and evidence electronically and so on. We did that for only one year, and nothing came of it at all. We were advised that there were some technological issues that prevented that process from continuing and that they wanted to embed that service into the NHS before rolling it out to the independent sector. So, we have done that only once. Despite the fact that we had produced a lot of evidence and uploaded all of that, it disappeared into a black hole. So, self-assessment is a bit of a sore point for most of us.

[359] **Gwyn R. Price:** Obviously, as you do not have self-assessment, do you monitor yourselves?

[360] **Ms Amery:** Yes. We will do our own internal audit and self-assessments, but not in conjunction with HIW.

[361] **Ms Healey:** We are all part of quite big UK organisations as well as being independent sector providers in Wales. We have that internal process, but we welcomed that opportunity to do the self-assessment audit. We were disappointed, as Nicky said, having

made all that effort, to get very little feedback and then for the process to end.

[362] **Gwyn R. Price:** We have already had evidence this morning that perhaps things do not go anywhere. Is that how you felt?

[363] **Mr Bartley:** When we went through the formal self-assessment exercise with HIW—as you probably realise, CSSIW still uses a self-assessment tool, but HIW no longer does—it was very detailed and a huge amount of information was uploaded. The feedback was done at a conference in Llandrindod Wells, but it was so basic and poor that it had not been worth our while going, to be frank. It told us nothing from the process. It gave a couple of ratings, but they were really not of any value.

[364] **Ms Amery:** As a reassurance, HIW and the regulation and inspection processes are a part of what validates what we do; they validate our own standards. All of us as organisations—both independent and those who are part of a wider group across the rest of the UK—have pretty rigorous and stringent quality standards internally that we impose on ourselves. As part of our regulation, we have to have four internal inspection visits every year. We do a lot of that internally anyway to ensure our standards. If I am really honest, I have found myself during the course of some of our inspections showing off the stuff that we already do, because it has not already been thought about. That has become increasingly so in the last few years, when HIW has taken a more risk-based approach rather than a structured framework approach to inspection. We still have a lot of framework internal inspections and audits internally within the organisation, and we hang off that, and we have a balanced scorecard, and all those red, amber and green ratings, which we share across all our hospital groups. Therefore, we do a lot of benchmarking within our sister hospitals, and I know that the other organisations across the UK do the same. However, as providers, I think that we seem to be stretching ahead of where HIW is. That would be my view.

[365] **Gwyn R. Price:** That is a fair comment.

[366] **Ms Healey:** When HIW came out to inspect us in the March, it came back out in the December to go back through the quality assurance, so that it could issue us with a report, because, clearly, there had been a failing. We shared our internal process and the mechanisms that we have within our organisation, and it was very impressed. However, the bit that is frustrating for us is that we believe that we can learn from the NHS, and that the NHS can learn from us, but there does not appear, at this point, to be that joined-up approach in respect of sharing that information and building a framework that is constructive and conducive to the quality services that we are all trying to achieve.

[367] **David Rees:** Thank you. William Graham has the next questions.

[368] **William Graham:** In your evidence, you state that you have been calling for greater transparency in governance and performance standards for many years. You go on to state that nothing has happened and you give some—in my view, at least—very constructive proposals. Would you care to enlarge on that?

[369] **Ms Amery:** Certainly. This is something that all of us as members of the Welsh Independent Healthcare Association have discussed over the course of the last few years, and we have raised the issues several times verbally with various members of HIW. In the last two years, we took a more formal approach, and requested—and received, to be fair—twice-yearly discussions directly with HIW. Those have mostly been attended by Steve, me, and our secretariat, at HIW offices, and HIW executives have also come to our quarterly meetings, which has been very helpful. There has been an amount of discussion around the aspirational goals for HIW, which is great, but very little on the delivery. After many years of dialogue, I finally wrote formally last December to HIW, expressing the recommendations and the

suggestions of how we could collaborate, because it seemed as though we were asking for information but were not getting anything. Therefore, I thought that we should at least make some suggestions about what it was that we thought we could do with, or could provide some guidance in. It was really to try to mirror the demands that HIW was putting on us in terms of reporting standards—if it requests information, we have to reply within two weeks, or whatever the standards are, and action plans have to be submitted within a fortnight. However, there was nothing reciprocating, in the other direction, so that is what the rationale behind several of those suggestions was. They were received very well, but still nothing has changed, and we still have no indication that any of these measures or standards are going to be self-imposed by HIW. So, we are still waiting for progress.

[370] **William Graham:** Thank you.

[371] **David Rees:** Thank you for that. I have noticed the time; we are scheduled to finish at 12.15 p.m., but I intend to go on until 12.25 p.m., if that is okay with everyone. We will turn to Lynne.

[372] **Lynne Neagle:** I have three questions. We know now that there is an issue with delay in feeding back, but your evidence also states that annual inspections do not occur routinely, and, of course, HIW is meant to do annual inspections. So, I wanted to ask how widespread that is—is it just one or two that are missing out on the annual inspection, or is it a much bigger problem? Then, in the table that you have about concerns, you have stated that, anecdotally, WIHA is aware of alleged inconsistencies in HIW's approach to staffing levels in the NHS and in the independent sector. I wondered whether you could elaborate on that. Thirdly, on safeguarding, you have stated that a WIHA member has raised specific issues in relation to improvements that could be made, but that this is a matter that would require amendment, and that, therefore, the majority view is that these would appear to be adequate. I do not really follow the logic of that, which seems to be that, because something is a bit tricky, you are just going to leave it as it is. So, I just wanted to ask about that, please.

[373] **Ms Healey:** Regarding HIW's three-year work programme, we all get sight of that publication, with the promise of annual inspections. It is across the board that we are not getting the annual inspections that it states will happen.

12:15

[374] We have had only three inspections and we have been open for five years. At the beginning we were inspected to death. I understand that we were a brand-new organisation coming in, and it was incredibly constructive. We learnt a lot from that process. There is a problem across the board in respect of the frequency. When you have an inspection and then wait 18 months for a report, which, although we obviously now it, has not been published, we have no idea where we are in that system of the next annual programme. That is a problem across the board.

[375] **Ms Amery:** I think that an annual inspection is hoped for rather than received by most of our acute providers—in fact, all of our acute providers. We had an inspection in October or November 2009, and in January 2012, for example.

[376] **Ms Healey:** That is exactly the same as us.

[377] **Ms Amery:** To be fair, some of that has actually been positioned as being a risk-based approach. It may not have been a full inspection that we might have had, but the last inspection that we had was not a full inspection. It was an infection control inspection.

[378] **David Rees:** What was your second question, Lynne?

[379] **Lynne Neagle:** That was about the issues that you have raised about staffing.

[380] **Mr Bartley:** I think that the staffing issue is probably more of an issue within the mental health sector. It is something that most providers feel somewhat strongly about. We are quite aware of the difference between the NHS and us in that respect. Our staffing levels are generally far higher. We almost all had set out within our statements of purpose what our minimum staffing levels would normally be. Certainly the majority of the providers work far beyond that. What we found in the last 12 months, in particular, was that we were all deemed to not be able to demonstrate a model for assessing our staffing needs, which was quite a sudden shift from a point where there was quite an acceptance that actually the staffing levels that we were working towards were actually good or very good, and there was a whole new demand and we were told, 'Actually, your staffing levels might be inadequate. How do you prove it?'

[381] The difficulty that we generally face, of course, is that the dynamic changes on a daily basis, and sometimes far faster than that, in terms of the numbers of staff we will actually require at any given point. Of course, the recruitment of staff is not something that we can snap our fingers at and get people through the door the following day. By the time that we actually go through our processes, you are almost looking, to recruit any person, at certainly a minimum of eight to 12 weeks, particularly by the time that you go through some induction or whatever.

[382] So, I think that almost all of the providers are feeling this pressure at the moment in terms of what exactly HIW is looking for here, because there is no suggestion as to how we should look at it other than to answer this question: 'How did you arrive at this figure and what does it actually mean?' We would say, 'Well, we actually agreed these figures with you a long time ago, and have been updated from time to time and changed.' Clearly, there is a new model, but we do not actually have that model. We are developing models, and there are a number of us in pilot projects at the moment, looking at varying tools to actually do that. However, because of the complexity of the actual services that we work within, there are no accredited models out there that we could actually lean on and say, 'If we apply a formula of x plus y equals z, we would get our magic numbers', because they will change on a daily basis in any case. So, it depends on the dynamic on the day.

[383] **David Rees:** Thank you for that. In relation to Lynne's third question—

[384] **Lynne Neagle:** Yes, it was on the safeguarding. You flagged a concern that it would be too tricky because it needed a change in regulations.

[385] **Ms Amery:** Yes. Personally, I cannot answer on that, specifically. I am not entirely certain what the individual member was concerned about.

[386] **David Rees:** Would it be possible for you to write to us, perhaps, with clarification on that point?

[387] **Ms Amery:** I certainly can. Absolutely. Yes.

[388] **David Rees:** Okay. We will therefore move on to Darren.

[389] **Darren Millar:** My question is actually partly related to what Lynne was asking about. You mentioned that there is this anecdotal evidence of perhaps an inconsistent approach by HIW towards the independent sector compared with its approach to the NHS. I just wondered whether you could tell us a little bit more about that and whether there is a feeling that HIW is perhaps more heavy-handed in its approach to WIHA or more flexible in

its approach to the NHS when it comes to staffing levels—

[390] **Mr Bartley:** The primary difference is, of course, that the NHS is not regulated and, obviously, we are, so I suppose that HIW has a different standard of proof that it has to apply. To be frank, we actually all welcome HIW in and we welcome its feedback, because it helps us, in some ways, to really look at our service and, probably, to improve along the way. So, while I think that we all feel that the demands are far higher on the independent sector than on the NHS, almost without a doubt—we have staff regularly coming from the NHS into our services who are completely bowled over by the level of clinical services and the level of staff that we provide—at the same time, we are very aware that if you were to look for public reports, what you would find is that the mental health independent sector would look, on the face of it, like a pretty poor service and one that has a lot of criticism addressed towards it, and there are no similar reports about the NHS whatsoever. So, it is a very uneven playing field. That is something that a lot of our stakeholders are commenting on, particularly the relatives of clients and, often, our clients, who will have access to our reports. We are obliged to share them. Most of the time, particularly in the mental health sector, they will have been in NHS facilities at some point in their life—the independent sector is rarely their first care or treatment experience—so they have a comparison to make, but when they read the reports, they often say, 'This is saying you're awful'. They can quite often make a direct comparison.

[391] **Darren Millar:** It seems grossly unfair, does it not, Chair? If a service is being commissioned by the NHS at one of your establishments, you ought to be inspected on the same basis and challenged to meet the same standards as the NHS facility that you are, effectively, providing services in lieu of.

[392] **Mr Bartley:** Theoretically, yes, and I think that that is something that everybody would welcome. I can see the complication in it and, perhaps, the model in England with the Care Quality Commission, where all the hospitals are registered—that is, the NHS facilities are registered as well as the independent sector facilities—would perhaps go some way to measuring that. Having said that, the CQC experience, particularly post-Winterbourne, highlighted that, actually, it did not work there either. So, it is different, but certainly it is a strong perception that we have, and a lot of our stakeholders comment on it, saying 'You don't look as good as the NHS', but the people actually experiencing it will say something different.

[393] **David Rees:** That is a question that you are going to ask HIW one day. I call on Leighton to ask the last question.

[394] **Leighton Andrews:** I just wondered whether you could contrast the system in Wales with any experience that you have from other jurisdictions in the UK.

[395] **Mr Bartley:** Personally and from the mental health side, I cannot. Some of my colleagues might have hospitals there, but I am based in Wales.

[396] **Ms Amery:** It has certainly been a few years since I have worked in England, but, obviously, we do have knowledge of the inspection and registration regimes in England, particularly, and in Scotland, both from Nuffield and Spire healthcare. It is very clear that HIW, CQC and the Scottish inspectorate work in parallel, but at slightly different paces. CQC appears to have taken a much more robust and proactive approach to some of the findings recently in England. I would say that it is a bigger organisation, therefore there is more resource capability and more proactive focus. I usually see copies of the recommendations and the nature of the inspection visits that are undertaken in our sister hospitals in England, and they are pretty robust, but they are also quite consistent in their approach. Despite regional variations, there does seem to be a much more structured approach to inspection.

[397] Over the years—I am embarrassed to say that I have been involved in running hospitals for just over 20 years—what I have found is that there has been a pendulum swing in the way that inspection regimes have operated, particularly in England. I suspect that the same thing is true in Wales. That is partly to do with the fact that registering, inspecting and running that regulatory framework is difficult to do effectively, as is finding the right balance between being structured and systematic and being able to benchmark across different providers, allowing for the individual flavour of each community, and, particularly in mental health, the nature of the patients who are being treated. It is a difficult thing to do, but it is more robust in England.

[398] **Ms Healey:** I support Nicky's statement. We were the first hospital as part of the Nuffield group to come into Wales. The feedback to us in respect of the Care Quality Commission framework understands that we are in Wales, and we have had some very good experience with HIW in Wales as well. However, there is certainly a much more integrated approach by the Care Quality Commission—there is a partnership approach, there is much more engagement, the reports are far more constructive and the timescales are better. It is important to say that the manoeuvrability and the information available on the CQC website to providers and support services such as us that provide services is far easier for the public and for us to manoeuvre. It is much better. I lean quite heavily into the English model as well as the Welsh model; I try to balance good governance with demonstrating quality of service.

[399] **David Rees:** Thank you very much for that. I thank Karen Healey, Nicola Amery and Steve Bartley for attending and for your evidence today. You will receive a copy of the transcript for factual corrections. Thank you very much for coming in today.

[400] Committee members will note that we will complete the evidence gathering for this inquiry on 7 November, when we will receive oral evidence from the Healthcare Inspectorate Wales and the Minister for Health and Social Services.

12:27

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

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

the committee resolves to exclude the public for items 7, 8 and 11 of today's business in accordance with Standing Order 17.42(vi).

[402] Are all Members happy with that? There are no objections.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:27.
The public part of the meeting ended at 12:27.

Ailymgynullodd y pwyllgor yn gyhoeddus am 13:33.
The committee reconvened in public at 13:33.

Cyllideb Ddrafft Llywodraeth Cymru ar gyfer 2014-15—Sesiwn i Graffu ar Waith y Gweinidog
Welsh Government Draft Budget 2014-15—Ministerial Scrutiny Session

[403] **David Rees:** Good afternoon and welcome back to this afternoon's session of the Health and Social Care Committee. This afternoon, we will be looking at the Welsh Government's draft budget for 2014-15. We have the Minister for Health and Social Services and the Deputy Minister for Social Services with us this afternoon. I welcome Mark Drakeford AM, the Minister for Health and Social Services, and Gwenda Thomas, the Deputy Minister. I also welcome David Sissling, director general of health and social services; Martin Sollis, director of finance; and Albert Heaney, director of social services, children and families. Thank you very much for attending.

[404] Minister, thank you for your paper. Thank you also for the paper on this year's allocation of the extra £150 million; I know it was late—we had it over lunch—but it is much appreciated and gives us some answers to questions raised last week. On the basis of this, I will ask the first question, and it is only one, simple, question on the calculation process for the distribution of this money. Could you explain that process, and has the same process been applied for the extra money for next year as well, because this paper clearly indicates that it is in response to the Francis element?

[405] **The Minister for Health and Social Services (Mark Drakeford):** The distribution of the £150 million that you will have seen today is essentially on a population share basis with a Townsend twist to it in taking some of the inequality dimensions of Townsend and applying it to that. That is how you end up with the shares that you see today. You will have seen from the Minister for Finance's announcement that there is £150 million this year and £180 million next year. My intention is that the £150 million that you have seen today will broadly be allocated to health boards in the same way next year, so that they can regard the share that they are getting as recurrent, and therefore are able to plan on that basis for next year, as well. That leaves us a small residual additional amount for next year, which I am yet to determine.

[406] **David Rees:** Thank you very much for that answer. We will go straight into questions and the first question is from Gwyn Price.

[407] **Gwyn R. Price:** Good afternoon, everybody. To what extent have you liaised with other Ministers with overlapping portfolios, for example, the Minister for Finance and the Minister for Local Government and Government Business, to ensure that financial resources are used effectively to achieve overarching objectives?

[408] **Mark Drakeford:** Thank you for that question. The answer is that I discuss aspects of the health budget with almost every other member of the Cabinet, there being an overlap in our agenda and other agendas on so many different dimensions. So, I will talk to the Minister for Economy, Science and Transport about issues of mental health, for example, where they have such a big impact on the economy. I talk to the Minister for Education and Skills about medical education where we have a shared agenda there. I sit on a committee with John Griffiths about physical education and the obesity agenda.

[409] To give you a slightly more extended answer in relation to the Minister for local government, who you mentioned, Gwyn, the Deputy Minister and I and Lesley Griffiths have been meeting all local authorities in Wales on the same footprint as their local health boards—I think that we have one more to go—and we meet together in that way. One of the express purposes is to look at budgets—those that come through the health service and those that come through social services—to see how they overlap. We have heard some very

encouraging things from some local authorities and local health boards about joint appointments and jointly commissioned services and so on, where the money that comes from different strands of the Welsh Government is being put to joint use at the service delivery end.

[410] **David Rees:** The next question is from William.

[411] **William Graham:** You will recall, Minister, that the last time that you were with us that we asked you about unscheduled care and the pressures accordingly. Could you give an idea of how these funding arrangements are being simplified to provide some clarity and transparency?

[412] **Mark Drakeford:** Thank you. Mr Graham, you will remember that, prior to the last discussion that we had, we also had a number of discussions about ambulance services in the unscheduled care context, and that is particularly where the McClelland review talked about funding methods and trying to ensure that they were simplified and clarified. I had a particular decision to make, therefore, in relation to the £150 million: whether the share of that money that might go to ambulance services in the unscheduled care context should go direct to the Welsh Ambulance Service NHS Trust, or whether it should go via the local health boards. I decided that, in order to be consistent with what I have said previously, in future, the simplified arrangement will be that money will go to the LHBs. They will be the commissioners and they will decide how much money they need to spend to secure the ambulance service that they need in an easily identifiable way. I decided that I should send the money for that aspect of unscheduled care to the LHBs this time as well—in other words, set a pattern for the way in which these things are to be done after the 1 April next year, so that we have that extra clarity that we need.

[413] **William Graham:** I respect your decision, but how are those outcomes going to be measured? We do not want to keep on saying that the ambulance service did not meet its target et cetera. One would like to see where the money went and how it was spent.

[414] **Mark Drakeford:** Of course. On the one hand, we have a clearer system for tracking the money. The second part of your question is: how do we know that the money has made any difference? In the unscheduled care arena, we have a whole plethora of different targets and measures that we use.

[415] Once again, you will know that the McClelland review said that the current set of ambulance targets have very little clinical relevance in terms of outcomes. We have a piece of work going on at the moment. I am very keen to have a different and more clinically relevant set of measures for the ambulance service, but they will not be in place until 1 April next year. Even when we have them, we will maintain the assurance that I gave in the Chamber to both Kirsty Williams and Darren Millar, I think, that the raw data that we publish will still allow the eight-minute response time to be tracked by people who want to do that.

[416] **David Rees:** Minister, you just talked about unscheduled care. It is a wider picture, and not just about the ambulance service, obviously. How do you ensure that you get value for money on that wider basis, because it incorporates primary care as well, making sure that patients do not come in? So, how are you going to work out value for money to ensure that the funding that you allocate to that is working?

[417] **Mark Drakeford:** In some ways, that is simply part of the everyday business of the health service. We are constantly monitoring the way in which investments that we make in health services lead to outcomes at the patient end. That is true right across the unscheduled care system. We do not run the unscheduled care system for Wales from Cathays park. The money goes to local health boards and then they make decisions locally, both in terms of their GP services, their hospital services, and the other things that they need, in partnership, very

often, with the third sector and social services departments, to secure best unscheduled care outcomes for patients. They then report data to us and we track their performance through our performance measurement arrangements. When we think that they are not providing us with the performance that we think we are entitled to receive, we have intervention and escalation arrangements to allow us to intervene in their performance. It is not a separate system, and it is not something particular to unscheduled care; it is everyday business for the health service.

[418] **Lynne Neagle:** First, I want to ask about the Wales Audit Office report that we discussed during one of your recent appearances before the committee. You will recall that I asked about the audit office's claims that operations were being cancelled at the back end of the year in order to save money. I asked David Sissling about it because you assured me that that was not your experience of what was happening, but you did say that you would take a look at it. I wonder whether you have had any update on that.

[419] **Kirsty Williams:** They were postponed, not cancelled.

[420] **Lynne Neagle:** Yes, postponed.

[421] **Mr Sissling:** Yes, we have looked at it, and we have looked in detail at the levels of cancellation and the circumstance of cancellation. It was very much as reported to this committee, and it might indeed have been reported on the same day to the Public Accounts Committee, when the question was raised. We have also looked at the level of cancellations since that period, which have reduced. To go back to the more general point, the plans that are now being developed for this winter, which have been subject to rigorous scrutiny, and indeed for the further period beyond that—the three-year plans that are developing—we are looking at these as part of a suite of indicators to make sure that we have the right alignment between understood demand, capacity and the ability to meet the demand through the NHS system and through partnership with other agencies, particularly the local authorities.

[422] **David Rees:** If I can expand upon that slightly, clearly, the pressures that arose as a consequence of that caused the difficulties. We have already had responses from the Minister on the surge of availability as a consequence of that, but, in your calculations for your budget allocations, did you consider the actual number of operations still waiting to be dealt with as a consequence of the delays last year, and are those taken into consideration when you make the budget allocations for this year to ensure that we do not see those numbers growing?

[423] **Mark Drakeford:** The budget allocation was done on the basis of population shares with the inequality dimension that the Townsend formula introduces to that. Indirectly, that sort of answers your question, in that those health boards with the largest populations tend to have the largest number of operations that are postponed, and they get the largest share and, therefore, are the best able to address those things.

13:45

[424] Actually, behind the question I think is a view of the world that is not the world that I tend to have to operate in. I have a fixed sum of money. I do not have a set of printing presses that I can go to and say, 'I need more money for this', and therefore I do not. It is a fixed sum of money for all the things that the health service has to do, and the only way to allocate that fairly, in the end, I believed, was to take a basic population-share approach with some extra capacity to adjust for health inequalities. Out of that global sum, health boards then have to provide all the services that we require them to provide, from unscheduled care right through to general medical services, dental services—everything that they have to provide.

[425] **David Rees:** Elin, do you want to ask a supplementary question?

[426] **Elin Jones:** Yes, I am struggling slightly with this: you asked local health boards to submit plans to address A&E pressures, but how do those plans—and I guess those plans are costed plans—relate to the decision you take, which is to allocate funding on the basis of the already prescribed formula, or did the local health boards know in advance the amount of money that was available to be bid for? If they did not—and you are indicating, by shaking your head, that they did not know the amount of money to bid for—then how do their plans relate to the allocation that you have given? Are you confident that the allocation that you have given will meet the aspiration of their plans? Obviously, this is an allocation for one year, so your expectation is that this becomes part of the budget for next year, and that you are not looking for a new set of plans with a new set of budget bids.

[427] **Mark Drakeford:** The answer to the final part of the question is that it is exactly as you described. I expect this allocation to form the basis of next year's allocation and that they are able to plan on that basis. When local health boards were asked to prepare unscheduled care plans for the coming winter, they knew nothing of there being additional money to assist them in doing that. They were, therefore, having to plan within the budgets that they knew were available to them. It would not have been a sensible thing, from my perspective, to have had the allocation of the £150 million driven by a single strand in all the many things that health boards have to do, and that is why I did not pursue it in that way.

[428] **Elin Jones:** Would you then expect, if they were planning on the basis of their existing budget, that what you have announced now would be over and above their plans?

[429] **Mark Drakeford:** The Member is very well aware that health boards across Wales, right from the beginning of this financial year, have been declaring, month by month, outturns that suggest that they are not able to live within the means that were made available to them. What the £150 million does is to go some way to allowing them to do that. It does not in any way provide them with some sort of extra elbow room in which they are going to be able to do lots of new and exciting things. It will allow them, I believe, to manage their way through the year and get to the year end.

[430] **David Rees:** May I remind Members to focus on the budget for next year?

[431] **Darren Millar:** If the additional allocation is going to be based on this year's allocation, then it is of course pertinent to ask about this year's allocation. You mentioned that you would expect the extra resource to help the NHS get through to the end of the financial year, and it is an extra resource that I welcome, but the auditor general, in his 'Health Finances' report, identified certain gaps by each health board area. You have actually given more than the gap to Aneurin Bevan health board, for example—£8 million more than its predicted gap—and yet, Betsi Cadwaladr LHB, for example, is about £16 million short of the auditor general's forecast for the gap. Why are you giving more than is required, according to the forecast, to some health boards and insufficient amounts to others?

[432] **Mark Drakeford:** There was a fundamental decision, I felt, that had to be made. The £150 million could have been allocated on the basis on which I think you might say, historically, extra funding has been provided to the NHS in Wales, which is that you look to see where the biggest holes are—in other words, those people who have done the least to live within their means—and you hand those people the biggest handout. Those organisations that have done the most already and have put their houses in order get the least out of that way of doing things. I think that that way of doing things has been widely criticised in this committee and in the Assembly in the past.

[433] **Darren Millar:** To be fair, Minister, I would just challenge that assertion, because, of course, last year, extra amounts were again given to some health boards that were forecasting the smallest holes, perhaps, and lower amounts were given to those that were forecasting the

biggest holes. So, it has not been allocated necessarily over the past few years on that basis.

[434] **Mark Drakeford:** I think that if you look over recent years—

[435] **Darren Millar:** It has not.

[436] **Mark Drakeford:**—you will find that we bail out those people, to use a term that you would use, rather than one of mine—

[437] **Darren Millar:** I am glad that you recognise that it as such.

[438] **Mark Drakeford:** You hand the money to those people who are furthest away from being in a situation of financial efficiency, and you penalise as a result, because you offer the least money to those people who have already done the most. I felt I wanted to break that cycle; I did not want to use this money on the basis that those who have done the most get the least and those that have done the least get the most. That is a difficult decision to make, because, in some ways, the easiest thing is to use the money in a way that does fill the biggest holes. However, I felt that a population-share basis was fair to everybody and that it did not—to use a pejorative term that I do not actually like and do not really share—reward failure and penalise success.

[439] **Darren Millar:** I am very pleased to hear that you want to reward success, but I still do not understand why you would want to give £8 million more to a health board that does not need that money but will be required to spend it under the existing arrangements because the new rules will not kick in until some point in the future. I have asked my question, anyway.

[440] **David Rees:** Yes, and I have to say that the answer has been given as well. Leighton has a short question, and then we shall go back to Lynne.

[441] **Leighton Andrews:** On this point, it is important to have some consistency in what is being put to you by Members, and the only basis on which Darren Millar can assert that any particular health board does not need the money is his reading of the WAO reports. I do not myself accept the premise, because, clearly, the approach that you have taken is not the same as the one taken by the auditor general; you have actually applied the Townsend formula to this, and I very much welcome that. I also very much welcome your approach in ensuring that those I once described in the second Assembly on the Audit Committee as ‘serial offenders’ in terms of health overspends are not automatically reinforced in their inability to make efficiencies.

[442] Can I be clear, though, about the Townsend formula going forward? Is that now going to be built into the forward planning of NHS finances going forward?

[443] **Mark Drakeford:** The concerted attempt to apply the Townsend formula ran for about four years, between 2004 and 2008, and it was done, as Members here will recall, on a basis of differential distribution of growth. When growth stopped, the concerted attempt to implement the Townsend formula ended with it. I have said, with the chief medical officer in particular, that I think that this means that we have to revisit the formula allocation here in Wales. A project is in hand, and the chief medical officer has been shaping it with others. It is a long-term proposition, but I still think that the underlying rationale for Townsend, which was that we should match our health spend where need is greatest, was the right one. We have not been able to do as much as we would like to have done in a time of real austerity, and we need to revisit that formula to make sure that we are able to resume our efforts in that direction as soon as we are in a position to do that, and we are putting ourselves in a position to be able to do so.

[444] **David Rees:** I have a very, very short question from Elin, and it has got to be short and on this topic only.

[445] **Elin Jones:** Yes, it is on the formula for the distribution of money, in relation to NHS pressures and winter pressures in particular. Every time we have had a response from Government in the past on winter pressures, we are told of the changing demographic and the older population and the age change of the population. I would therefore be interested to know how the changing demographic has featured, if at all, in the allocation of funding for unscheduled care.

[446] **Mark Drakeford:** I might ask Martin Sollis if he knows any of the detail better than I do. Population share includes a weighted dimension within it—it is not just a simple amount per head. It is weighted within it for demographics. Martin will know more.

[447] **Mr Sollis:** Those population figures are updated too.

[448] **Elin Jones:** Population share is not just per head, it is—

[449] **Mark Drakeford:** It is not a simple—

[450] **Mr Sissling:** It is adjusted to take account of a number of factors. We are trying to map the resources on to health need, rather than just the number of people living in a particular area.

[451] **David Rees:** Lynne, we will go back to you now.

[452] **Lynne Neagle:** Are we going to ask all our questions in one go? Is that the idea?

[453] **David Rees:** You can ask your questions; go ahead.

[454] **Lynne Neagle:** I just wanted to ask about the mental health budget. You have indicated that you are going to continue with the ring fence. How satisfied are you that that is being complied with on the ground? In relation to legislation, there is a small allocation for the implementation of the Food Hygiene Ratings (Wales) Act 2013. I know that there has been a consultation, but how satisfied are you that that will be satisfactory, given the squeeze that we anticipate being on local government? I will also the Deputy Minister a similar question to the one I raised in the Children and Young People Committee. This is the first year where the Government will not have put in the specified protection for social services. It is also a year when we are going to see unprecedented pressures on local government. What assurances can you give the committee that social services expenditure is going to be adequate in this budget?

[455] **Mark Drakeford:** I will do the first two questions first. In relation to mental health, mental health budgets are ring-fenced. The money inside the ring fence has grown considerably; it was £387 million five years ago, and it is £587 million now. We put the £5.5 million set aside for implementation of part 1 of the Mental Health (Wales) Measure 2012 into the mental health ring fence this year. I think that it is action 8.2 of 'Together for Mental Health' that commits us to a review of the ring-fence arrangement in 2015, and we will maintain the mental health ring fence until then.

[456] In theory, I have some reservations about ring-fencing, but where mental health is concerned I am very practically attracted to it. I feel very determined that we have to do as much as we can inside the Assembly, because mental health gets such a small share of public attention compared to its importance as a subject to people who live in Wales. If we here are

not safeguarding it, keeping an eye on it, making sure that we talk about it and that it features highly in the work of LHBs, there is always a danger that it will slip back into being a cinderella service. In Wales, it is not; I am sure that you will have seen the stories earlier this week of difficulties in mental health services elsewhere.

[457] While we have challenges in our mental health services as everywhere else, when I go out and speak to mental health groups, as I did last week on Mental Health Day with third sector organisations, they still have an optimistic view of what has been achieved in Wales on the mental health front, through the mental health Measure, which was an entirely cross-party piece of legislation, and in the actions that have followed from it in primary mental health care. We have had 26,000 people assessed at primary care level as a result of the Measure. Over 1,000 people have been able to make an application for their secondary mental health care to be reviewed as a result of the Measure. While money is always an anxiety, the ring fence is our best protection for it, and at the moment I think that it is still allowing our development of mental health services in Wales to be progressive and developmental.

[458] On the second point in relation to food hygiene, there is a small amount of money—£110,000—set aside for the implementation of the Act from the Welsh Government side. There is a substantial additional sum of money in the Food Standards Agency's budget to support it as well. The £110,000 is what was identified in the regulatory impact assessment. I end up saying to my officials and people involved in it: 'The question is not to come to me and say how much you need; you know what you've got and you now have to be able to deliver what is needed within that sum. There is no other money; that's what you've got.' I have seen reports of the extra training sessions that we are putting on for staff in local authorities for the extra practical information that they will need, and I am confident that the money will be sufficient to do that.

14:00

[459] **The Deputy Minister for Social Services (Gwenda Thomas):** Thank you for that question. I will start by saying that we are in an unprecedented retrenchment here by the UK Government. Of course, we have had to think about the budget and how we protect it in that light. We certainly will not be turning our backs on children, adults, and the older adults who can only live by depending on services that are available. It was always known that the 1% protection would be for three years, and local authorities were well aware of that. It is fair to say that there is much variation out there in terms of social services outcomes and the cost of delivering services. So, this has to be about a new way of working.

[460] Our expectations have been made absolutely clear: we expect to see much more change and innovation. The core production of services and new models of services have to be a way forward. That is what 'Sustainable Social Services for Wales: A Framework for Action' has been all about. That has been published since 2011 and, in fairness, we have seen local authorities take that on board and work in partnership with the health boards and the third sector, and there are excellent examples of this integrated working. I would like to say that the announcement of the £50 million in partnership with Plaid Cymru and the Liberal Democrats will give us a way to consider how that money can be invested in protecting services, and I look forward to working with the two parties in developing the thinking around that.

[461] **David Rees:** Do you want to come back on that, Lynne?

[462] **Lynne Neagle:** It would be nice, when that work is completed, if the committee could have a note on how the £50 million will be used. That would be really useful.

[463] **Kirsty Williams:** I would be interested to understand how you are ensuring that the

resources in the budget allocation for next year and the year after are aligned to achieving the Government's strategic aims, as outlined in the programme for government and specific targets. Are you confident that the service has been financed in a way that will allow them to deliver on their targets? So, if they do not, it is not a question of there being a lack of resources, it is that other operational issues have led them not to be able to meet targets.

[464] **Mark Drakeford:** Well, this is an austerity budget for an NHS in an era of austerity. I certainly do not come here claiming that there is plenty of money out there and that money is not a factor in the way in which the programme for government can be delivered, because it certainly is a factor in it. It is by no means the only factor. We have very carefully looked at the money that is available to the NHS next year and the year after. I am confident that the programme for government priorities can be met. I am equally determined that we will go on throughout the period testing the programmes that we have in the NHS to see whether they are delivering against the ambitions that we had for them in the first place and, where they are not, that we release that resource to do something different and better.

[465] I would like to give one example of that that the committee will be very familiar with. You will know that Public Health Wales undertook a major review of all of its health improvement programmes. It reported the outcome at the end of September. It identified the fact, in an evidence-based way, that there were a series of programmes that had been attempted—and they were attempted with all of the right sorts of ambitions—but it turned out that they were not, in the evaluators' views, delivering on the outcomes that had been anticipated. Therefore, Public Health Wales has said that it would like to switch the resources out of those programmes and into some new programmes that it is developing to tackle childhood obesity. That is a way of doing things that we are going to have to do even more rigorously over the next two years. So, I think that there is money in this programme to deliver all the programme for government commitments, but we will continue to assess everything that we do. Where we are not getting the outcomes that we had hoped that we would have for the investment that we are making, we will switch the investment into programmes that we think have a better chance of doing that.

[466] **Kirsty Williams:** May I clarify that, because the narrative of the draft budget is perhaps not as clear as it might have been with regard to the additional £180 million for 2014-15 and the £240 million for 2015-16? Are those allocations specifically for the implementation of changes arising out of Francis or are they a more general allocation to meet targets? If they are specifically for post-Francis developments, what outcomes will we see for that investment?

[467] **Mark Drakeford:** The exercise that was undertaken over the summer was very much in the Francis context. It looked at the extra pressures in the health service that the Francis report identified. Francis looked at extra pressures in unscheduled care, for example; it looked at pressures of staffing on wards; and it looked at new developments in the health service that have to be funded. So, the money that we have this year and which will be carried on, as we have said, is very much there to meet the additional Francis demands. You will see that, during next year, as in this year, the extra money will go into the vaccination programme, with four extra vaccines available in Wales. It will continue to allow us to pay for Kalydeco as the first of the new generation of ultra-orphan drugs. It will allow us to maintain the £10 million for additional nurses in the health service, so that we reach Francis compliance in our surgical and medical wards, and it will allow the health service to meet those other demands that come from changing demography, additional acuity, unscheduled care pressures and all the other things that Francis identifies.

[468] **Kirsty Williams:** Finally, may I ask how have you gone about ensuring that, with regard to LHB service reconfiguration capital requirements, resources have been allocated and identified to deliver on those plans? I am particularly interested in the identification of the

resources to build the specialist and critical care centre that you announced yesterday.

[469] **Mark Drakeford:** Thank you; I think that that is a really important question. I am very keen to try to give assurances to people in those parts of Wales where there have been plans already agreed, or there may be plans in the pipeline for the reconfiguration of services, that we have the capital resource identified to support the changes that will be needed. So, I was very pleased earlier in the summer to announce the £5 million for Tywyn hospital in north Wales. Last week, I think that I was able to announce the £1.9 million for the remodelling of the minor injuries unit in Llandudno, which is part of that. I meet quarterly, I think, with the team of people who work on the capital programme here, and I say to those people all the time, 'I want to see the proposals coming through the pipeline from Betsi Cadwaladr, for example, in relation to Blaenau Ffestiniog and Flint, so that people can see that the promises that were made to them as part of the reconfiguration are being supported in the capital programme'. I know that we have identified sums in our capital programme to support exactly those changes. So, having gone through it in quite a lot of detail with officials, I feel confident that we are aligning our capital programme with the reconfiguration agenda and that the money is there to bring about the changes that are needed.

[470] I was very pleased, this week, to be able to announce the money for the next stage of the SCCC—it is a substantial sum of money that has been announced—to allow the local health board to develop its final and full business case. I think that this is a big step forward in relation to the SCCC. When the capital expenditure comes to be drawn down from our central capital budget, it will be over a number of years. We have profiled what will be needed in those years. It is a substantial investment, but it is affordable within the capital programme, and we will still be able to go on doing other necessary things while the SCCC is being afforded.

[471] **Rebecca Evans:** I wanted to ask about continuing NHS healthcare. The deadline for the national project for retrospective claims for people who were wrongly charged is June 2014. However, the Wales Audit Office has said that the project has made limited progress so far and that there is a risk that the deadline will not be met. So, are more resources being directed to this project? Would you need to extend the deadline, and, if you did, would that have an impact on the moneys required for it?

[472] **Mark Drakeford:** We do not agree with the auditor general. We think the project will be delivered on time; we have invested substantial additional resources in Powys local health board, which is responsible for clearing the backlog of CHC claims. The director general of the NHS wrote to the chair of the Public Accounts Committee, explaining why we reach a different conclusion to the auditor general in this particular instance, and I am sure he can let you know why we did so.

[473] **Mr Sissling:** First, we have anticipated a potential problem, and, last year, we made some additional funding available to the NHS through Powys to increase its capacity. It was match funding; the NHS health board put money in on an equal basis, which allowed us to develop the capacity, which involves special investigators, legal representatives and administrative support to allow the pace of clearance to be increased. That capacity is in place and is now working through the backlog and all the projections show that it will complete its work in April. That gives a couple of months of headroom, but that headroom is important, because that then allows the finalisation of the process locally. It goes from Powys, which does the consideration of the case, then back locally for the finalisation, which obviously involves interaction with the individual—the claimant—or their relatives. So, we are confident that we will clear that, and, indeed, what I was able to say last week is, because the system seems to be working well, it might well be a shame to dismantle it in the early part of next year. Should we not consider—and we will consider—a continuation of the arrangement because there is a further backlog that has developed since then, and it seems wise to use a

proven method to address that.

[474] **Darren Millar:** May I just ask a follow up question on CHC? I was very pleased to hear that the backlog is being addressed, but you also indicated, Mr Sissling, the change in the decision-support tool and there was a question about whether that would be applied retrospectively for cases that had already been assessed, if you like. There would obviously be a financial implication if it were to be applied retrospectively. Has that been accounted for within the budget provision going forward?

[475] **Mr Sissling:** No. That is still work in progress because the decision-support tool, and indeed some of the other things that we were able to say that we were bringing into line—what was seen as acknowledged good practice—has to be subject to a period of consultation in November, December and January, followed by a post-consultation assessment, with implementation in the early summer. It will be during that process that we need to understand all the potential implications.

[476] **Rebecca Evans:** The Deputy Minister described the unprecedented situation that we are facing, so I was wondering how much longer you think we can sustain the £50 cap on domiciliary care, and are you satisfied that local authorities will be able to deliver it this year?

[477] **Gwenda Thomas:** I think I have made it clear that I am looking at the level of the cap. It has been very widely welcomed; we know that. The Minister has made available an additional £3.2 million per annum, which would be paid through the revenue support grant to local government this year. This is on top of the £10.1 million that has already been allocated to it. There are increased costs and we know that one has to look at this level. I am committed to doing that from April of next year, but I will be announcing a consultation on this very shortly.

[478] **Rebecca Evans:** Even beyond that extra £3.2 million, I think that still leaves a funding gap for local authorities of around £2 million. How would you expect them to find that money given the difficult situation they are in?

[479] **Gwenda Thomas:** The £10.1 million was local authorities' own assessment of what the gap would be. We worked on that and we have had the evaluation and monitoring exercise and we have published that, and what local authorities said after the first year. We have now agreed to make this extra £3.2 million available, and we will look at how that will be distributed.

14:15

[480] **Darren Millar:** I just wanted to ask about the money that has been allocated for the NHS Redress (Wales) Measure 2008. One problem that appears to be manifesting itself in different parts of Wales is the timescales by which concerns are investigated and resolved. We also know that many health boards are having to make significant contingency arrangements for the possible pay-outs, because of their own self-insurance processes. Do you think that you have allocated sufficient resources to allow the complaints system within the NHS, and the redress system that is there, to be able to cope with the demands being placed on it, given the rising number of complaints that appear to be emerging?

[481] **Mark Drakeford:** Chair, specifically in relation to the NHS Redress (Wales) Measure 2008, there is £1.8 million in these budgets to allow local health boards to deal with claims arising from the Measure. The advice that I have is that, in the early days of the scheme—it is only in its third year now—a significant part of the money made available to local health boards was taken up with set-up costs, staffing costs, staff training costs and so on. We expect that, by this year—certainly by next year—the whole of the amount of money

that is being given to local health boards will be available for the settlement of claims, because the system costs will now have been taken up.

[482] In the first two quarters of this year, claims to the Welsh Government from LHBs came in at £499,000 against an overall annual budget of £1.8 million. We fully understand that there will be claims from the first two quarters that have yet to come through the system. I was not aware of issues to do with timescales, but I will ask the director general whether we know anything on that. Our current estimates are that we think that the budget is sufficient, but it is a budget that LHBs draw down from us. We will continue to monitor carefully with them whether it is enough to meet the claims that come through a Measure that we are very pleased to have put on the statute book and think provides a quicker, easier and more successful means of providing for the claims of patients.

[483] **Mr Sissling:** We are not aware of any general issues about timeliness. We are, however, more generally requiring health boards and trusts, where appropriate, to improve the speed and responsiveness of the way that they handle complaints. This is just one element of it, and we believe that there is a more general issue that the health boards need to improve their systems at times, increase the capacity that they have in the areas and increase the engagement, at times, of those who support these processes. It is a priority, so while we focus on this, it is a broader issue for us in terms of this really important area.

[484] **Darren Millar:** I appreciate also, Minister, that you are doing lots of work around the unscheduled care agenda at the moment, and that you are working up different proposals. However, you have not allocated any specific resources to the potential 111 service that you are considering, or you do not appear to have done so. What contingency arrangements have you got in place should there be a call for some investment in a new 111 service for Wales?

[485] **Mark Drakeford:** There will not be a new 111 service in Wales in the next financial year, certainly. The timescales may mean that it will be introduced in some parts of Wales, or in some aspects of healthcare, in the following year. I continue to see the very important role that a new 111 service could provide in Wales in the unscheduled care field: if, for example, we were to try to move in a concerted way to a phone-first approach to unscheduled care, in which everybody would be encouraged to phone and get advice as to the right place for them to get the care that they need.

[486] However, as Members will know, where 111 has been implemented elsewhere, it has not always had the easiest of rides. We have retained NHS Direct in Wales and, of course, regarding the last 37 contracts that were let to NHS Direct for 111 in England, NHS Direct had to withdraw from them there. So, at the moment, my feeling, Darren, is that I want to learn from what has gone on across the border and in Scotland as well. I think that there is real potential in the 111 service, but I want to do it when we are confident that we can get the maximum value for it in Wales and that we have ironed out some of the potential pitfalls that may exist for it.

[487] **Darren Millar:** I have one final question, if I may, Chair, on the 'Together for Health' cancer delivery plan. I know that there have been discussions many times in the Chamber about whether there is a need for a cancer treatment or drugs fund of some sort. The Rarer Cancers Foundation recently challenged you on your assertion in relation to many drugs not being available in Wales or not as easily accessible in Wales as in other parts of the UK. Do you not think that it is about time that we made some resources available to level the playing field on that front as well?

[488] **Mark Drakeford:** I was comforted by the report that Public Health Wales published over the summer regarding the last 12 months' experience of the individual patient funding requests system in Wales. It shows that it has some significant strengths, which I think are

sometimes being under-represented in the way that we have talked about it. About six out of 10 applications through the IPFR system are approved. It is clear to me that applications are carefully looked at and that there is a good chance of success for patients for whom clinicians are able to demonstrate exceptionality. Of course, you can apply through the IPFR process not simply in relation to cancer drugs, but in relation to any condition that you have. However, having looked at the report, I think that there may be ways in which we can further strengthen it in Wales. I have had recent discussions with the director general, as it happens, about the regional variations that that report demonstrates and how some health boards have higher numbers of applications through IPFR and tend to have higher success rates too. That may—I stress 'may'—lead you to conclude that some of those drugs ought to have been made available in the first place, without people having had to go through the IPFR process, and would have been had those applications been made in another part of Wales. So, we are thinking about whether a new national dimension to the IPFR process would strengthen the consistency of decision-making across the whole of Wales, and we are going to do some serious work in thinking about that. I do not know whether David has anything to add.

[489] **Mr Sissling:** It is work that we will pursue with some urgency. So, it will be subject to engagement with those involved in the process, but with a starting point that needs to build on all of the many strengths. It is the issue of consistency; we need some kind of national quality assurance arrangements or some national mechanism by which we can assure that. We will seek to do it as soon as we can.

[490] **David Rees:** I have questions from Elin, Kirsty, Leighton and Lindsay.

[491] **Elin Jones:** Weinidog a Dirprwy Weinidog, hoffwn ddweud, fel yr wyf wedi dweud mewn cyfarfodydd blaenorol ar gyfer craffu ar y gyllideb iechyd, fy mod yn ffeindio'r gyllideb hon mor rhwystredig â chyllidebau blaenorol, gan fod yna un llinell gyllideb o £5.4 biliwn, ac felly mae'n anodd craffu ar y llinell gyllideb honno mewn manylder. Gan hynny, a chan eich bod yn edrych i greu deddfwriaeth er mwyn cael cyllidebau tair blynedd, neu er mwyn newid y sail ddeddfwriaethol ar gyfer cyllidebau'r NHS, a oes gennych chi unrhyw fwriad i newid sut y bydd y gyllideb honno'n cael ei chyflwyno i'r Cynulliad? Un mater penodol yw'r ffaith fod y gyllideb ar gyfer llywodraeth leol yn debyg, i ryw raddau, i'r gyllideb hon, ond y gwahaniaeth yw bod y Gweinidog llywodraeth leol, yn ystod y broses o graffu ar y gyllideb, yn cyhoeddi sut y bydd yr RSG yn cael ei wario yng Nghymru a'r *allocation* RSG i awdurdodau lleol. Fodd bynnag, hyd y gwn i, nid ydych chi'n gwneud unrhyw beth tebyg a fyddai'n rhoi gwybodaeth inni am sut y bydd y gyllideb hon o £5.4 biliwn yn cael ei dosrannu. Yn ogystal â hynny, rydym, yn y gorffennol, wedi dod yn ymwybodol bod gan y gyllideb iechyd *contingency fund.* A allwch chi rannu gyda ni lefel y *contingency fund* yr ydych yn ei chario ar eich cyllideb gyfan

Elin Jones: Minister and Deputy Minister, I would like to say, as I have said in previous meetings for scrutiny of the health budget, that I find this budget as frustrating as previous budgets, as there is one budget line of £5.4 billion, and so it is difficult to scrutinise that budget line in any detail. As a result of that, and as you are looking to create legislation in order to have three-year budgeting, or to change the legislative basis for NHS budgets, do you have any intention of changing the way in which that budget will be presented to the Assembly? One specific issue is the fact that the local government budget is similar, to a certain extent, to this budget, but the difference is that the Minister for local government, during the budget scrutiny process, publishes how the RSG is spent in Wales and the RSG allocation to local authorities. However, as far as I know, you do not do anything similar that would provide us with information as to how this budget of £5.4 billion will be distributed. As well as that, in the past, we have become aware that the health budget carries a contingency fund. Can you share with us the level of that contingency fund on your entire budget for the next year?

eleni?

[492] **Mark Drakeford:** Diolch am y cwestiwn. Rwy'n gobeithio ein bod ni wedi llwyddo i roi ychydig yn fwy o fanylion am y cyllido sy'n digwydd y tro hwn i'r pwyllgor, achos mae rhai pethau ar ddiwedd yr adroddiad sy'n dangos mwy nag o'r blaen. Rwy'n awyddus, ac rwyf wedi bod yn siarad â'm swyddogion, i weld a oes mwy y gallwn ei wneud y tro nesaf hefyd er mwyn rhoi rhagor o fanylion o dan y lefel uwch er mwyn helpu aelodau'r pwyllgor. Rwyf wedi bod yn meddwl gyda'm swyddogion, ar ôl y ddadl ar lawr y Cynulliad, ynglŷn â beth yr ydym yn mynd i'w wneud â'r Bil newydd i weld a allwn ni gryfhau'r broses o graffu ar y cynlluniau sydd gennym dros y tair blynedd. Rwy'n gobeithio, cyn diwedd yr wythnos nesaf, ysgrifennu at aelodau'r pwyllgor i awgrymu rhai ffyrdd lle gallwn wneud hynny a chael sgwrs gyda phobl i weld a oes pethau eraill y gallwn eu gwneud i gryfhau'r broses o graffu. Mae swm yn y gyllideb ar gyfer y flwyddyn nesaf—mae £25 miliwn yn y *contingency fund* sydd gennym.

Mark Drakeford: Thank you for the question. I hope that we have succeeded in giving some more details about the budgeting that is going on this time to the committee, because there are some things at the end of the report that show more than we showed previously. I am eager, and I have been speaking with the officials, to see whether there is more that we can do next time as well to give more detail under the higher level in order to help committee members. I have been considering with my officials, after the debate on the Chamber floor, what we are going to do with the new Bill to see whether we can strengthen the scrutiny process for the plans that we have over three years. I hope, before the end of next week, to write to committee members to suggest certain ways of doing that and have a conversation with people to see whether there are other things that we can do to strengthen the scrutiny process. There is an amount in the budget for next year—there is £25 million in the contingency fund that we have.

[493] **Elin Jones:** O'm cof i, mae hynny'n swnio'n llai na'r hyn y mae wedi bod yn y gorffennol. A allwch chi ddweud wrthym beth oedd y ganran yn y gorffennol o'i chymharu â'r ganran y flwyddyn nesaf?

Elin Jones: From memory, that appears to be less than it has been in the past. Can you tell us what the percentage was in the past as compared with the percentage for next year?

[494] **Mark Drakeford:** Mae Martin yn dweud iddo fod yn £30 miliwn o'r blaen.

Mark Drakeford: Martin says that it has been £30 million in the past.

[495] **Kirsty Williams:** I noted earlier that the budget had been aligned with the programme for government. The two key manifesto commitments at the last election were the health checks for everyone over the age of 50 and enhanced access to GP services. I note from the budget that you have allocated £0.6 million for the over-50s health checks and there is no additional money to provide access to GP services. Could you outline how many over-50s do you anticipate will be in receipt of the health check when it is fully implemented in 2014 on the basis of the £0.6 million allocated? With regard to access to GPs, you have identified figures of £1.8 million and £3.1 million to enhance access outside core opening hours, and that will be a realignment of enhanced services that are already in existence to match the key priority. Could you say which enhanced services are not key priorities and, therefore, will be disinvested from to provide for the enhanced access out of core hours?

[496] **Mark Drakeford:** The sum of money set aside in the budget next year for the over-50s health checks is just over £600,000—it is about £648,000—and it will allow us to take the next stage of this plan forward. Having maybe got off to a slightly sceptical start about it, I found myself being drawn more into the enthusiasm of those people working on the scheme who are very positive about it.

[497] **Kirsty Williams:** Maybe I could meet them and become enthusiastic. [*Laughter*.]

[498] **Mark Drakeford:** Kirsty, we will introduce you to them to be enthused as well. Members will know that it is a web-based approach. The sum of £648,000 will allow us to do four things in the coming year. It will allow us to continue to develop the web-based resource itself, which is expanding all the time in terms of what can be made available through it. It is going to allow us to work with 10 Communities First clusters in the first instance. I am very well aware of the issues that arise when you are doing something on an electronic basis, in terms of the digital divide and access. So, we are working with Age Cymru to make sure that the way we do it is going to be genuinely accessible to people right across the community. There are 10 Communities First clusters where we are going to be piloting it and we are starting that by the end of this month. Part of the money will be to work with them. Then there is money for Public Health Wales, because Public Health Wales is to be the quality assurer of the information that goes up on the website.

14:30

[499] One of the really important things about having the system is that we know that there is a vast amount of material out there on the web about health matters, and it is often very difficult indeed for an individual to know whether something is reliable information or if it just the sort of stuff that if it were quality assured you would be told not to follow. So, Public Health Wales is going to quality assure everything that goes up on it. Also, there is dedicated money for marketing to make sure that people hear about it as well.

[500] As it is a web-based approach, and once we are sure that it is doing the job that we want it to do in the way in which we want it to do it, then it will not be expensive in the sense of making it available to anybody in Wales who may want to take advantage of it. One of the things we are very keen on is to have a website that is alive and which people will want to revisit, and not something that they look at once and then think, 'Well, I have seen that'. We will be adding to the material on it all the time. I may have mentioned this already, but I have been keen recently to talk to the people who are designing it about making sure that it has some capacity to help people think of the idea of advance decisions. There is a group of people in Cardiff University who are working on a way that people can declare decisions in advance of when they might be called upon and needed, in a way that will legally stick at the time. They are developing quite useable standard forms that people can use, and that will be available through the over-50s health check as well. So, there are new things being added to it in that way. I think that it will turn out to be a much more interesting, useful and exciting way of doing things than we might once have thought.

[501] **Kirsty Williams:** How many people are going to receive the health check in 2014? How many people do you anticipate will access an over-50s health check in 2014?

[502] **Mark Drakeford:** It is not easy to answer that at the moment, until we have been to the 10 Communities First cluster areas to see what the take-up will be and to see what we are able to do to bring it to people's attention and persuade them to do it. We will have an idea then. Of course, it is a resource for people, is it not? It will not be compulsory to visit the website, so it will rely on what we can do to bring it to people's attention and to stimulate an interest in it.

[503] As far as GP services are concerned, the enhanced service figures you have in the paper are illustrative. They show what it would cost if we were to get 33% of practices in Wales to offer appointments after 6.30 p.m., or if 50% of them were doing that. We are doing a piece of work with LHBs at the moment to get a better sense of what we think the demand for appointments after 6.30 p.m. will be in reality. I have always said, and I am very happy to say again, that appointments after 6.30 p.m. in the evening are important for people who are in work and may not be working near where their GP practice is and do not want to have to

take a whole morning off in order to get a simple blood test taken. They are not appointments aimed at people who are well able to get to their GP during standard working hours. They have to be additional and targeted at people who really need them at that time of day. We will learn through the LHB work exactly what level we think that needs to be. I will ask David if he can give you some idea of the things we currently cover through the enhanced designated service arrangements and where we think money could be moved around to cover those costs.

[504] **Mr Sissling:** There is a considerable number. I have the list here and, out of interest, I am counting them up—I have got up to between 90 and 100, and there are many more. They cover an enormously wide range of areas that include, for example, wound care, minor injuries services, musculoskeletal services, learning disabilities services, smoking cessation services; I could go on, because, as I said, they are probably into three figures. At the moment, we are working with LHBs and the GP community to look at these in detail to understand what scope there is for redistribution of any money. We have not come to a decision at this point in time, but we will do in the very near future in terms of which ones would be the basis on which we could support the extended opening hours of GPs into the evenings.

[505] **Kirsty Williams:** I would appreciate a note explaining where that money has been disinvested from, when that decision is taken.

[506] **David Rees:** We will leave the answer on that one.

[507] **Leighton Andrews:** I want to ask you about the timescale for conclusions from the inverse care law programme. Have you identified any interim conclusions?

[508] **Mark Drakeford:** Thank you, Leighton. I might ask others for the detail on this. As you know, we are doing work on the inverse care law in two areas—in Cwm Taf and Aneurin Bevan. They have been developing models of what an enhanced primary care presence in those disadvantaged areas would look like. We think that the work is a little bit further advanced in Aneurin Bevan at the moment than it is in Cwm Taf. We have commissioned two academics—Stephen Palmer, and somebody else, whose name, I am sorry, has just escaped me—at Cardiff University to review the plans that are coming forward so that we are confident that, if we are to try to find any extra resource to bolster that, the money will be spent in the best possible way. David might have a better idea of the timescale.

[509] **Mr Sissling:** It is about to switch from design of the arrangements to implementation. Certainly, when I met with Aneurin Bevan health board recently as part of our mid-year review, it was impressive in setting out its thinking, which goes beyond, perhaps, where it started from, which was more GPs, to a contribution of GPs that was more general across different work areas. It also involves other professional contributions and, importantly, a quite innovative form of engagement with communities, to, in a sense, empower communities. So, it is about much more care and support being provided by communities for communities. It will be initiating that over coming months. I am meeting with Cwm Taf in a similar way tomorrow, so we will be in a position to assess its plans then.

[510] **Leighton Andrews:** Is the funding for this dedicated funding?

[511] **Mr Sissling:** Increasingly, we are asking the health boards to reprioritise and to see this as a means by which they can support ventures such as this. So, we are asking them, with a whole range of different developments, to take this into account as they do their three-year plans. Their three-year plans will now be finalised in January. We had the latest version in September, which showed considerable progress from ones that were provided earlier this year, in order to get the planning right. Now that they know their allocations for the next two years, they can firm up their plans, which they will do. In the case of these two health boards,

this will be an integral part of them.

[512] **Lindsay Whittle:** I would like to follow on from that, as one of my questions was on the inverse care law programme. I have been an elected representative on five different authorities—

[513] **Leighton Andrews:** Too many.

[514] **Lindsay Whittle:** I was put there by the people, you see. I have heard this before, 38 years ago. How are we measuring the outcomes? If it did not work 38 years ago, how confident are you that it is going to work now? You are redirecting money into areas and, quite frankly, it is not successful. We have not been doing it right, so what evidence is there that we are going to get it right this time, please?

[515] **Mark Drakeford:** I do not think that we should lose sight of the fact that the NHS itself is the biggest contribution to addressing inequalities that this country has ever seen. Everything that the NHS does, by its very nature and the fact that the only qualification for getting help is clinical need rather than the ability to pay, means that it is the single biggest engine for addressing inequality that we have ever had. Of course, there is more that it needs to do, and we are constantly frustrated by the fact that the gap in health between the best off and the least well-off is so difficult to narrow. One of the reasons for that—sorry, I am going to bore a couple of people now, because I said this in front of the children committee yesterday—is that we tend to over-focus on the little bits of extra money that we badge as being about health inequalities. One of the nicest things I have got to do in the many years that I have worked at the Assembly was to go out with Peter Townsend when he was developing his formula, to meet groups in the different local health boards. He used to get very frustrated and angry with people who would ask him about the little bit of extra money that they were going to get through the Townsend work. He used to say to them, 'Don't ask me about the £50 extra that you're going to get from me; you tell me what you're doing with the £500 million that you've got already. There's no point in me giving you a little bit of extra money just to find that you spend it in the same way as you do now, which doesn't address health inequalities'. Part of the reason we have not always made the gains that we want to make is that we do not have a enough of a thorough look at the whole of the budget that local health boards and local authorities have to make sure that they really do match their spend to need. It may be easier to say that than it is to do, and we know that some groups in the community have louder voices and are better able to lobby and get decisions made that are to their benefit than some groups that are less able to articulate their needs or to get their voices heard. However, it is a good point that you make and it is an ongoing frustration.

[516] **Lindsay Whittle:** I do not disagree with a single solitary word that you say. I have not seen the success yet, but I genuinely look forward to that. I live in these places, for goodness' sake; you are talking about me.

[517] **Mark Drakeford:** We should not talk ourselves down so much that we think that nothing is being achieved—

[518] **Lindsay Whittle:** Yes, there is a lot of good work as well.

[519] **Mark Drakeford:** The gap between the top and the bottom is narrower than it was 37 years ago, but it is not narrow enough—

[520] **Lindsay Whittle:** I may be a dreamer, but it is not happening as fast as I want it to, and I am sure that it is not happening as fast as you want it to, Minister; we agree on that one.

[521] I want to ask a question about the situation with the hospices. I understand that the

money, in real terms, is going down by about 7.98%. During recess the Chair of this committee and I visited hospices, and the amount of work that they do is first class, but in Wales we receive far less per proportion per expenditure than they do in England, Scotland and Northern Ireland. By reducing the amount of money to hospices, what impact will that have on our national health service? If these people are not in hospices, they will come back into the NHS.

[522] **Mark Drakeford:** I agree with everything that Lindsay has said about the importance of hospices and the job that they do. There is £400,000 less in next year's budget, in the hospice budget line, than there was this year. That is because they have spent £400,000 less than was allocated to them. So, there will be no reduction in service at all next year. Everything that has been provided and that is being paid for this year will be provided and paid for next year. The reduction in money is money that was not drawn down and used for those purposes. In these difficult days, where there are examples of budgets that have been estimated in the past, and have been found to have been estimated a bit higher than was needed, we have no choice but to look at those budgets and redirect that money to another purpose. So, everything that has been paid for this year will be paid for next year, including the specialist nurses and the consultant rotas; all of the things that that money buys will continue to be paid for next year.

[523] **Lindsay Whittle:** That is an understandable explanation and one that I totally agree with, but do we look at which hospices are underspending and which ones are in desperate need?

[524] **Mr Sollis:** We continually look at the spending on the hospices.

[525] **Lindsay Whittle:** That was not the message I was getting during the recess, but I will go back to the people now.

[526] **Mark Drakeford:** Please do, because the money is actually allocated through the palliative care implementation board, which Ilora Finlay chairs. The formula that it used was hammered out with a good deal of difficult negotiations about four years ago. I am sure that she would want to know if the formula needs to be looked at again or whether there are parts of the system that feel that they do not get a fair share.

[527] **Lindsay Whittle:** This is my final question. The Minister for Finance's statement says that there will be no extra money available for any unforeseen cost of the implementation of any new legislation. We are told that the Social Services and Well-being (Wales) Bill, for the 2014-15 financial year, will be reasonably cost-neutral. Are we still confident of that statement?

14:45

[528] **Gwenda Thomas:** I have made that clear from the beginning. If we look back to sustainable social services, we will see that it was not based on money; it was based on working in different ways, and that is what the Bill grew out of. There are resources being made available—for example £2.1 million for the implementation of 'Sustainable Social Services for Wales'—to build capacity within local government. I made it clear in the Chamber last week that there would be help with implementation and that remains the position, of course. I did give you a list then, and I can repeat that. I have mentioned the £2.1 million. The regulatory impact assessment that I published in January made clear that we would bend the workforce development programme, which would make available over £8 million for training and would be aligned to the requirements of the Bill. We also made available an additional £622,000 to support the safeguarding agenda, which is very important indeed—setting up the adult protection boards and the new local safeguarding children

boards, for example. There is also a further £50,000 to the Association of Directors of Social Services for the commissioning of resources to further develop plans for the national adoption service, and £1.5 million has been made available to local authorities and their partners to build capacity locally, and to begin preparing for implementation. I have also said that I will make two statements on finance and I gave you the details of those. Also, we will be updating the RIA in the course of Stage 2.

[529] **Lindsay Whittle:** Thank you, Deputy Minister. It has been my experience in the past that collaboration is perfect in a perfect world, but sometimes there are people who use the finance issue to not collaborate and I think that those people need to be strictly monitored if this is to be successful, as I want it to be and as you do, of course.

[530] **Gwenda Thomas:** I accept that. To follow up on what the Minister said on the last question, we have to be mindful that the actual budget that we have here—the £46 million for budget programme provision—is less than 4% of the resources that will be made available to local government social services through the RSG. That is the extent of the money that is out there and that needs to be spent in a different way with innovative ways of integrated working, as you say.

[531] **David Rees:** William, do you have a question?

[532] **William Graham:** I have two questions. First, why are you discontinuing the protection given to the social services budget?

[533] **Gwenda Thomas:** I am sorry?

[534] **William Graham:** Why are you discontinuing the protection previously given to the social services budget?

[535] **Gwenda Thomas:** The continuing protection of 1%?

[536] **William Graham:** Yes.

[537] **Gwenda Thomas:** I think that I answered that earlier on in answering Lynne Neagle's question. It was always known that that 1% protection would be for three years and local authorities knew that. With the financial restraints that we are facing, the issue of protecting that 1% became difficult, and we know the decision that was taken.

[538] **William Graham:** Okay. On that basis, if you cannot do that, how are you going to maintain the £50 per week for the cap on charges?

[539] **Gwenda Thomas:** Lynne Neagle did bring this up; I am looking at the £50 cap. It has been there for a while now.

[540] **William Graham:** There is no specific answer on that is there?

[541] **Gwenda Thomas:** Pardon?

[542] **William Graham:** I am asking whether you will be able to maintain it.

[543] **Gwenda Thomas:** I have said that I am looking to increase that from April next year. There are increased costs and other issues that need to be considered—benefit changes, for example. However, I will be consulting on that before a decision is taken.

[544] **David Rees:** Darren, do you have a question?

[545] **Darren Millar:** Yes. I just wanted to ask the Deputy Minister about the Commissioner for Older People in Wales's budget. It is obviously a flat cash budget, but there is a cut in real terms. When the commissioner came to see us earlier this month, she indicated that there was some pressure on the capacity of her office to meet the demand that was being placed upon it because of the high profile of the role. As the older people's commissioner's office becomes more known across Wales, more and more people are contacting her with concerns. Are you confident that the resource that you have allocated will be sufficient to deal with that increase in demand, particularly given the important role that the commissioner has in ensuring improvements in health and social care and given that we were all glowing about the work of her office just earlier this week?

[546] **Gwenda Thomas:** I very much recognise the value of the independent role of the commissioner and the various policies that she is supporting us with in regard to looking at advocacy, the business case and other things. I realise that everybody's budget is being squeezed. The £1.7 million is a flat budget, but it is the best that we can do and we have protected it at that level. I look forward to meeting with the commissioner and discussing with her any concerns that she has with regard to that; we will of course do that. That is the decision on the budget, and the £1.7 million will be protected at that level.

[547] **Darren Millar:** You will keep this under review should she be able to demonstrate a significant additional demand on her services.

[548] **Gwenda Thomas:** No, the budget has been agreed now for next year. What I can discuss with her is whether she thinks that what she has been asked to do is piling on the pressure. I must say that she has been very willing to take up these roles and to participate, particularly in the work of the older people strategy, in which she was very instrumental in achieving the reference site status. We are very grateful for that. However, the budget has been set at £1.7 million and it is protected at that level.

[549] **Darren Millar:** I have just one final question on advocacy, if that is okay, Minister. Obviously, you have indicated that the social services Bill will allow for some independent advocacy to be provided to people under certain circumstances and with clear criteria. Have you decided whether that will be something that you will fund from within your budget or whether that is something that you would expect people to pay for themselves?

[550] **Gwenda Thomas:** I am looking at the charging section of the Bill, of course, and I have given a commitment to that. However, the business case that I have already mentioned, which the older people's commissioner is helping with, will hopefully give us a clear way forward with regard to the establishment of independent advocacy. I would look to consulting on that and deciding how we best fund it when we know what that business case will be.

[551] **Darren Millar:** However, you have nothing in the budget at the moment.

[552] **Gwenda Thomas:** There is the programme budget, which covers many projects and can cover advocacy. I do not have it, but before very long we should have the result of the work that the commissioner is chairing. We will be more than happy to share that and to discuss the way forward.

[553] **David Rees:** Minister, I will ask a question while I have the chance. Obviously, the health service is very much about dealing with people with ill health, but we also want to prevent people from becoming ill. What proportion of the budget are you looking at to allocate or consider for preventive services? I appreciate that the £5 billion allocated to local health boards is very difficult to break down in that sense, but I suppose that I am asking for an indication as to what you think they should be looking at, particularly in terms of

immunisation and vaccination, and also perhaps screening services.

[554] **Mark Drakeford:** You are right, Chair, it could be a very difficult question to answer in terms of a bald proportion right across everything that the NHS does. Around 45% of the budget of Public Health Wales is spent on screening programmes, specifically in relation to the issues that you mentioned at the end. We have a whole range of screening programmes in Wales, which are constantly kept under review. We take advice on the national screening programme and we have our own Welsh screening programme. Members here will be aware that there have been some fairly significant changes introduced to the cervical screening programme as from September this year. There will no longer be cervical screening for women aged between 20 and 25 because the evidence was that it probably did more harm than good, and there is a reduction—

[555] **Lindsay Whittle:** Not for all.

[556] **Mark Drakeford:** No, indeed. Not for all, but overall as a population-based programme. For women aged over 50 the screening will be reduced to once every five years rather than once every three years. Those are changes that have already been introduced in England and Northern Ireland. We introduced them here in September.

[557] In terms of our national bowel screening programme, in common with other parts of the United Kingdom, the take-up of the screening has slipped back a bit over the past couple of years. There is a big effort being made now by the people who run the programme to think of new ways in which we can persuade people to take up the screening. It is very skewed by gender—women are very good at taking part in that screening programme, men much less so—and it has a strong class gradient as well, yet we know that it is an immensely effective programme for people aged 60 and over who may be in the very early stages of bowel cancer. We introduced the new aortic aneurysm screening programme in Wales for the first time this year, so we have a major programme of screening that we know is preventative in its purpose, and is very successful, too. In relation to vaccination and immunisation, we are introducing the four new vaccines this year, and there is more money being found in this year's budget as part of the Townsend review. That money will be carried forward into next year, when it will have to go up again because the new vaccines are part-year costs in this year. We will know better by the end of this financial year what the take-up rates are, for example, in the screening programme at the age of 70 and 79 for shingles; in the rotavirus screening programme for very young children; in the new flu vaccine—it is not a vaccine, as we know around this table, but a nasal spray for two and three-year-olds, and people in year 7; and in the new arrangements for meningitis C vaccinations. There is £7.9 million for vaccinations in this year's budget, going up beyond that next year. All those are very important parts of preventative spend, and I think, through Public Health Wales, we have a national approach to these things. We are able, as we have seen in the measles outbreak, to mobilise extra resource when we particularly need it, and we have a pretty good track record.

[558] **David Rees:** You have identified that some of the take-up is poor, and therefore I assume that some of that budget allocation is actually for promotion of those screening activities as well.

[559] **Mark Drakeford:** There is promotion money alongside the actual delivery of the service every year.

[560] **David Rees:** I have one more question—everyone else is quiet. On the capital budget, clearly we have not talked much about the capital budget, and we are in times of difficulty, and we have seen the capital budget reduce dramatically. Has the Welsh Government looked at innovative ways to raise funding for the capital budget in the health area?

[561] **Mark Drakeford:** Thank you for that question. I will just try to be brief by answering on one dimension particularly. We are definitely having to be interested in new and innovative ways of finding capital for health service purposes. I have been able to take advantage of discussions with the Minister for Finance and, through her, with Gerry Holtham and the very small team that he has, on working on innovative methods here for the Welsh Government.

[562] The most concrete proposal that we have, which is still at a very early stage, is to be thinking about an innovative capital investment at Velindre NHS Trust, for the new cancer centre there. As some Members will know, the land that was at Whitchurch Hospital has now been transferred to Velindre, and so they want to move on to their next stage of redevelopment. It is about £200 million. It would use that new land and give Wales a cancer centre fit for the twenty-first century, able to use all the other investment we have made at Velindre. That £200 million, alongside the SCCC and the other things that we want to do, is a very large core. In some ways, Velindre, because it is a trust, has some extra financial freedoms beyond those that LHBs have. It is also, compared to most health organisations, a bounded organisation; it is there for a very particular purpose: it provides cancer services, whereas so many of our other organisations are much more diverse in what they do. It has income streams as well, because local health boards pay money to Velindre every year for the services that Velindre provides to them, and compared to any other health organisation in Wales, it has a substantial flow of charitable funds into it as well. These characteristics, we think, make Velindre the most promising candidate we have at the moment for the innovative funding model. Gerry has been up to Velindre and met with the executive team there. I spoke earlier this week to Rosemary Kennedy as the chair, and to Simon Dean as the chief executive, about it. They are certainly enthusiastic about exploring this possibility very actively with Gerry and his team, and from the ministerial perspective, I am keen to give those discussions a very fair wind.

[563] **David Rees:** Thank you very much for that answer.

[564] **Darren Millar:** May I ask a very small supplementary question on that?

[565] **David Rees:** Yes.

15:00

[566] **Darren Millar:** I was very pleased, Minister, to hear your positive response about looking at opportunities for the NHS to perhaps be able to borrow more in order to invest in its capital. I assume that that is what you were referring to, really, in relation to Velindre. The auditor general suggests that there is about £352 million-worth of non-Government income that the NHS receives on an annual basis, which is a significant funding stream against which the NHS ought to be able to borrow, in my opinion. Will you require legislative tools to allow for that to be properly managed, or are we talking about something completely outside legislation, and therefore perhaps more difficult to monitor?

[567] **Mark Drakeford:** Just at the moment, in the Velindre context, the trust rules look as though—

[568] **Darren Millar:** Okay.

[569] **Mark Drakeford:** We will get definitive legal advice no doubt in due course, but there may be the room for manoeuvre so that they would not need legislative change in order to be able to do it. We may want to do it more broadly across the health service, and I have been taking up some of the suggestions that have been made on the floor in relation to the financial flexibility Bill, not with regard to being able to do it there, but in thinking about

what legislative change we might need to have if we are to allow a wider use of borrowing against income streams that the health service in Wales has more broadly.

[570] **David Rees:** Thank you, Minister, for you answers. I thank you and the Deputy Minister for your attendance and for the evidence that you have given this afternoon. I think that there were a couple of things that you said you would get back to us on. We look forward to those answers. Thank you very much.

[571] **Mark Drakeford:** Thank you.

15:01

Papurau i'w Nodi
Papers to Note

[572] **David Rees:** Members will please note the letter that we have received from the Deputy Minister for Social Services relating to the Social Services and Well-being (Wales) Bill, and the letter from the Chair of the Finance Committee on the fairness in finance toolkit, which was circulated a fortnight ago.

[573] As we agreed before lunch, we will now go into private session for item 11.

Daeth rhan gyhoeddus y cyfarfod i ben am 15:02.
The public part of the meeting ended at 15:02.