



Cynulliad Cenedlaethol Cymru The National Assembly for Wales

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

**Dydd Mercher, 4 Gorffennaf 2012
Wednesday, 4 July 2012**

Cynnwys Contents

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

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

Papurau i'w Nodi
Papers to Note

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynndi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd. Mae hon yn fersiwn ddrafft o'r cofnod. Cyhoeddir fersiwn derfynol ymhen pum diwrnod gwaith.

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. This is a draft version of the record. The final version will be published within five working days.

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

Mick Antoniw	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

**Eraill yn bresennol
Others in attendance**

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

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

Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service

*Dechreuodd rhan gyhoeddus y cyfarfod am 9.59 a.m.
The public part of the meeting began at 9.59 a.m.*

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

[1] **Mark Drakeford:** Croeso i bawb. **Mark Drakeford:** Welcome to everyone.
Mae'r cyfarfod yn awr yn agor i'r cyhoedd. The meeting is now open to the public.

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

[2] **Mark Drakeford:** Croeso i Lesley Griffiths, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol. Gyda Lesley y bore yma mae Dr Chris Jones, Cyfarwyddwr Meddygol Gwasanaeth Iechyd Gwladol Cymru, a David Sissling, Cyfarwyddwr Cyffredinol, Iechyd, Gwasanaethau Cymdeithasol a Phlant Llywodraeth Cymru. Mae'r pwyllgor wedi ysgrifennu at y Gweinidog i nodi cyfres o faterion i'w trafod yn y cyfarfod heddiw, ond mae croeso i aelodau'r pwyllgor holi cwestiynau am faterion eraill. Rydym hefyd wedi cael papur gan y Gweinidog. Diolch am hwnnw. Fel arfer, rwyf am ofyn i'r Gweinidog a oes unrhyw sywladau agoriadol byr yr hoffai eu gwneud. Ar ôl hynny, byddwn yn troi at aelodau'r pwyllgor er mwyn iddynt ofyn cwestiynau.

Mark Drakeford: Welcome to Lesley Griffiths, the Minister for Health and Social Services. Accompanying Lesley this morning are Dr Chris Jones, the Medical Director of NHS Wales, and David Sissling, Director General, Health Social Services and Children for the Welsh Government. The committee has written to the Minister to note a range of matters to discuss in today's meeting, but committee members are also welcome to ask questions on other issues. We have also received a paper from the Minister. Thank you for that. As usual, I will ask the Minister to make any brief opening remarks that she wishes to make. We will then turn to committee members for them to ask questions.

[3] **The Minister for Health and Social Services (Lesley Griffiths):** Diolch. Good morning. I am grateful for the invitation to come here this morning to update Members on key achievements and progress to date on work across my portfolio. I have submitted the evidence paper, which highlights several areas where progress is being made in delivering NHS services to the people of Wales, in line with our programme for government commitments. I will not go through the paper; I am sure that Members will have read it, and we are happy to take questions.

[4] **Mark Drakeford:** Thank you, Lesley. We have an hour, and all committee members have questions to ask, so I appeal to people to be aware that other Members will also be waiting for their turn. I am going to ask Darren to start.

[5] **Darren Millar:** Good morning, Minister. There has been a lot of concern about the way that local health boards are very often taking what can only be described as emergency decisions about services in their area. Very recently, it was announced that there is a possibility that acute services might be removed from a district general hospital. You have given a very clear commitment that no district general hospitals will be downgraded in Wales. How do you reconcile that with the reality on the ground as far as health boards are concerned, and what guidance are you giving them about the availability of acute services at district general hospitals? Can you tell us what the definition of a district general hospital is? I have always assumed that district general hospitals ought to have acute medical services.

[6] **Lesley Griffiths:** There is no definition, really. There is no set of services that must be provided by a district general hospital. I think that that is where some confusion arises. You are obviously referring to the decision taken last week by Neath Port Talbot Hospital. I do not see that as downgrading. I was very clear in the Chamber yesterday afternoon that I do not see protecting the safety of patients and the safety of services as a downgrade. Those services are being removed from that hospital, but they will be provided elsewhere. This decision was taken by doctors because they were concerned for the safety of patients. It was not about resources. We have been very clear—I have certainly been very clear in the year and a bit that I have been Minister—that services are going to be moved. The NHS is a hugely

changing organisation. It has to evolve. However, what is of prime concern to me, and, I am sure, everybody around this table, is the safety of patients.

[7] **Darren Millar:** So, when does a district general hospital simply become a large community hospital, because that is, effectively, what a district general hospital without acute medical services is, is it not?

[8] **Lesley Griffiths:** No. I think that a district general hospital is what it says: it is a general hospital and provides a variety of services.

[9] **Darren Millar:** So, acute medical services can be removed from hospitals across Wales and they will still retain a district general hospital label, although, effectively, they will be providing services that are basically the same as community hospitals.

[10] **Lesley Griffiths:** You are picking on one set of services that is being removed from one hospital to another. Neath Port Talbot Hospital is—. What is the definition of Neath Port Talbot Hospital?

[11] **Dr Jones:** I think that if you were to ask the public whether it is a district general hospital, most people would probably say that it is. I do not quite understand the significance of the question.

[12] **Darren Millar:** The point is: what are the ingredients of a district general hospital? Are there any other district general hospitals in the country that do not provide acute medical services? To my knowledge, this will be the only one in the United Kingdom that does not.

[13] **Mr Sissling:** I would disagree with that. Increasingly, there are a number of variants on what a district general hospital is. The range of services at Neath Port Talbot in the future, for example, will be extensive and it will probably provide the majority of hospital care for the local population. There will be a vast range of diagnostic and outpatient services, and there will be a very important number of planned care services. The health board is planning to make it a centre of excellence for the whole health board area and beyond for services such as neurorehabilitation, aspects of urology care, breast surgery, orthopaedics, and it is looking to develop in vitro fertilisation services.

[14] It will be a very important hospital, which will also offer immediate care for people requiring attention to their immediate needs, through a GP-led service. The notion that there is a clear definition of a district general hospital with a range of prescribed services just is not the case anymore. There is much more fluidity and more recognition of the need for care in and out of hospital, with networks of care, where initial care is provided in one place and further treatment in a location nearer to home, perhaps. We are increasingly seeing a challenge to those traditional ways of looking at care in hospitals.

[15] **Darren Millar:** I have one final point. You listed a range of services there that will still be available at the hospital. I know of community hospitals that provide specialist services, diagnostic services and all those other things that you mentioned, but they are regarded as services of community hospitals. You also said, Mr Sissling, that other district general hospitals do not have acute medical services. Which specific hospitals, whether in Wales or elsewhere in the United Kingdom, are regarded as district general hospitals but which do not have acute medical services?

[16] **Mr Sissling:** I could not give you a list now.

[17] **Darren Millar:** That is because there are not any, is it not?

[18] **Mr Sissling:** I believe that there are.

[19] **Mark Drakeford:** If there are examples, it would be useful to have them provided.

[20] **Vaughan Gething:** I have a couple more questions on reconfiguration. I have had meetings with my local health board. I am interested in the move to new service plans and in the clinical case for any service changes. When the plans come to you, what do you expect them to say about the clinical case? Are you going to run any tests as to whether you are satisfied that a clinical case for service change has been made? Equally, I am interested in the level of guidance that you give in the consultation and engagement phase with the public and stakeholders like us about what you expect in that information about the implications for service change, from a clinical point of view. I know that there is lots of local politics, but my first considerations are whether there is a real case for change, and whether there is a need to do this from a clinical point of view. If there is, I am interested, and if there is not, I want to know what deliberate choice is being made otherwise.

[21] **Lesley Griffiths:** That is a very good point. I have not seen the plans; they are being formulated now. Betsi Cadwaladr and Hywel Dda health boards will be the first to go out to public consultation, probably towards the end of this month. In south Wales, because the plans there are for all LHBs plus Powys working together, they are going to take a little bit longer, and they will probably be going out in October. On whether there is a need for change, that is an important point. Maybe there will not be massive changes. I think that the changes will be much more subtle than we think. Health boards have been working closely with the national clinical forum, which was set up to advise health boards, and to make sure that they fitted in with our clinical priorities as a Government.

[22] This is a once-in-a-lifetime chance for this Government to get it right, but it has got to be right for the foreseeable future. In the longer term, we need to make sure that it fits into a whole-Wales plan, with an overview that health boards are not working in isolation, so services have to fit in together, a bit like a jigsaw. That is important, and I think that it is great that the south Wales health boards have worked together. That has been a real plus on that side. I will not see or agree to the plans until they have progressed to formal consultation, because of my role at the end of it, where community health councils can come to me. Officials will be reviewing the plans before progress to formal consultation. I will ask David to come in now, because I think that he will be seeing them far sooner. However, it is important that there is an evidence base to show that these services have to change. We know the difficulties that health boards are facing at the moment, and Darren referred to the emergency decision taken last Friday. Neath Port Talbot Hospital and the health board said that it was a shame that they had to do this as they were going through their consultation process, but it just shows why we have to change.

10.10 a.m.

[23] **Mr Sissling:** The emphasis from our perspective in assuring their plans is on there being a strong element of clinical engagement; on their having used contemporary clinical advice and evidence; their having carried out the proper processes of analysis of current and future demand on services, in line with the policy that is relevant including 'Setting the Direction', 'Together for Health' and the rural health plan, which is particularly important for some health boards; on their having done appropriate modelling of the capacity that they need in the future, including considering any capital investment or revenue implications well; on their having reached a point, through a thorough and rigorous process of engagement with stakeholders and the population, at which their plans for consultation are in line with good practice; and on their having clear processes to allow them to formulate the proposals and take those through to a decision over the coming months. So, that is the process, but, as I say, there is a strong emphasis on the clinical perspectives to ensure that, as they go into the active

consultation processes, there is a necessary stressing of the clinical implications of the changes.

[24] **Vaughan Gething:** On the advice that is given by the national clinical forum, how and when will it be published in respect of these service plans or change models that are being provided? How and when will they be made available to Members and to the wider public?

[25] **Dr Jones:** My expectation is that the national clinical forum will offer comments in public during the consultation phase once plans are in the public domain. At the moment, the national clinical forum is a very credible group of clinicians of a variety of different disciplines drawn from our professional advisory structures. The forum is meeting health boards and asking questions of them. It is calling them back to ask those questions again and ensure that the health boards have responded appropriately. The health boards cannot go out to consultation until they have had the agreement of the national clinical forum, and, during the consultation phase, the forum will then offer a view about the different options available.

[26] On the workforce, quality of care and outcome for patients, the other point to raise in response to your question is that the NHS chief executives sought objective advice about what constituted a better service. That was the reason to commission Professor Marcus Longley to do his independent academic work on the evidence base for different service models, and 'The National Case for Change' has shown some areas where there is a clear case for a change in service design and other areas where perhaps there is not such a strong case for fundamental change.

[27] **Lesley Griffiths:** Just to confirm, there will be a formal public response from the NCF.

[28] **Rebecca Evans:** On the listening and engagement exercises, particularly with regard to Hywel Dda, which finished recently, are you satisfied by the quality of that listening and engagement exercise? Do you believe that people have been genuinely listened to and engaged with, and what discussions have you had about the emerging themes that have developed from that listening and engagement exercise?

[29] **Lesley Griffiths:** Hywel Dda has been criticised greatly, but I do think that it tried very hard to up its game in respect of the listening and engagement exercise. It certainly extended it because of the criticism that it received. I have been very clear that any change will be guided by relevant clinical evidence, and it has taken that on board. I have also stressed that it has to engage at a level that it has never engaged at before. Certainly, officials have been speaking to it following that engagement exercise. You recently met with Hywel Dda, did you not?

[30] **Mr Sissling:** Yes. There are always areas that can be improved. In a very complex process, there is always learning about how things, going forward, could be advanced. It has paid an enormous amount of attention and had its engagement, to date, assessed and appraised, so there is an independent view of that. I have just received that and I will be looking at that and sharing the outcomes with the Minister, obviously feeding it to other health boards so that they can take advantage of the learning. It is also important to say that it has benefitted from the engagement. The plans there now are at the point of finalisation. The public consultation has been refined by what was heard through the engagement process, which is, I suppose, one of the tests: whether it has had a function utility in shaping its plans, and the answer is clearly 'yes'. It has found it extraordinarily helpful listening to the public, clinicians, and stakeholders, and that has allowed it to reflect on some of the positions that it had adopted and to take those forward into its proposals for the future.

10.15 a.m.

[31] **Rebecca Evans:** Would you be able to make that independent review available to the committee?

[32] **Lesley Griffiths:** I do not see why not.

[33] **Mark Drakeford:** Thank you very much. All members of the committee have indicated that they have questions, as I would have expected. Just so that people know, I am going to bring in Kirsty next, then Mick, Elin and then William before moving on to everyone else.

[34] **Kirsty Williams:** Following on from the questions about reconfiguration, the constant refrain in the Chamber is that these are matters for individual local health boards, but, in paragraph 13 of your paper to the committee, you say that the Welsh Government takes full responsibility for the reconfiguration of services. Obviously, the Cabinet paper that you took to your colleagues was quite explicit in your expectations of LHBs. What will you do as Minister if the LHB plans that are published do not match the aspirations expressed in your paper to the Cabinet?

[35] **Lesley Griffiths:** This is one reason why the national clinical forum is looking to ensure that the new arrangements are clinically safe. Obviously, that has to be the priority. Ultimately, the buck stops with me, and I recognise that, but it is the LHBs' statutory role and responsibility and they know their local populations the best. I mentioned that we will have to have an overview of the whole of Wales to make sure that it is coherent and that it fits in with our policies and strategies. They are having advice from the national clinical forum on the clinical side, and I am reassured. It has been a very long process and we have taken our time because, as I mentioned, this is a huge chance to ensure that health services in Wales are sustainable and safe for many years to come, and we have to get it absolutely right. Ultimately, it has to go through the community health councils, as well, and through public consultation. By the time the plans are formulated and come through, I am extremely hopeful that they will fit in with our strategies. As for what actions will be taken, that is to be worked through as we go through the next few months.

[36] **Kirsty Williams:** Moving on to the financial standing of the NHS, Chair. Paragraph 58 of your paper states that, as a result of these cost pressures, at the beginning of the financial year 2012-13, the LHBs report that savings of approximately £315 million are required for them to achieve financial balance. What percentage is that of the overall expenditure?

[37] **Mr Sissling:** It is in the order of 5%.

[38] **Kirsty Williams:** Actually, it is more than 5%, is it not? Given that it is more than 5%, it is interesting that, in your letter to the Finance Committee, when talking about NHS debts, you stated that the maximum savings target that can be delivered with any degree of confidence by an LHB is 5%. So, you are telling the Finance Committee that you cannot expect an LHB to save more than 5% in any one financial year, but your paper to us here today states quite clearly that LHBs will have to achieve over 5% if they are to break even. What confidence can we have in the ability of LHBs to achieve a goal, which, by your own admission to the Finance Committee, is not one that one could have any confidence in?

[39] **Lesley Griffiths:** Officials have received balanced plans from all local health boards, apart from Hywel Dda LHB, and officials are working very closely with Hywel Dda at the moment. I am very confident of six LHBs at the moment, and, as I say, officials are working with Hywel Dda to get it to come in.

[40] **Mr Sissling:** The confidence would be based on the performance of last year and previous years when similar savings were delivered. First, there is an evidence base and a track record of delivering savings to that level. It is no greater this year than last. The further thing to say is that the NHS is getting more accomplished in how it addresses those challenges, and it is not simply about savings and cutting costs. A lot of it is about looking at that as a financial challenge and seeing whether action can be taken to avoid costs being incurred in the first place. An example would be to see the underlying demand for increases in attendance at hospitals, which is associated with demographic pressure, and to introduce models of care that contain that in the community and primary care, which thereby reduces the load and the costs of hospital-based care. So, there is an awful lot of attention, using the integrated system, to ensure that we can both avoid the costs and improve the quality and accessibility of care, which is why we were able, last year for example, to reduce emergency admissions for some chronic conditions in the order of 15%, which is good for resources and good for patient experience.

[41] Beyond that, there is attention to a very significant number of different areas where we can drive out inefficiencies in the system, reduce waste and make sure that we are improving the quality of care. So, it is about reducing hospital infections, as we did last year, and reducing complications in hospitals and the length of stay. Those are the kinds of things that we are doing—trying to ensure that we are driving up quality and patient experience whilst addressing the financial challenge.

[42] **Lesley Griffiths:** I recognise what we have asked of the NHS. Last year, it was not a bailout when we helped those health boards; they were used to being bailed out year on year on year, and when I became Minister, I did not think that that was sustainable. They really worked very hard last year and to come in on the target that they did was amazing. Also, they have to do it on 31 March every year, so they should be praised for what they did last year.

[43] **Kirsty Williams:** I note that in the letter to the Finance Committee, 5% is a maximum that can be expected with some confidence. What the Government's paper here today tells us is that they are going to have to achieve over 5% in savings. Finally from me, when can we all look forward to the first person over 50 receiving their health check?

[44] **Lesley Griffiths:** As you are aware, at the moment, we are looking at the development of the over-50 health checks.

[45] **Kirsty Williams:** You have been looking at it for quite some time then.

[46] **Lesley Griffiths:** Well, it is a five-year term of government, Kirsty; we cannot deliver everything straight away. These policies and strategies are not done in isolation. They have to fit in with everything: 'Together for Health', the GP access, it all fits in together. As you know, we are in the development phase and a full proposal is being developed, and we are having a look at what professional groups can contribute; we have to look at the costs and the benefits. You will be aware of the programme for government timetable and the implementation is scheduled to take place between 2013 and 2016, so the development work is currently taking place in accordance with that timescale.

[47] **Kirsty Williams:** So, when will somebody be able to get their free health check? It was your big health pledge in the elections.

[48] **Lesley Griffiths:** It was one of them.

[49] **Kirsty Williams:** Along with the GP access, which we are not doing very well on either.

[50] **Lesley Griffiths:** We are doing very well.

[51] **Mark Drakeford:** Do you have a date in mind?

[52] **Lesley Griffiths:** I have just said that the implementation is scheduled to take place between 2013 and 2016.

[53] **Mick Antoniw:** Minister, it does not matter how much money we have; if we do not have the doctors, then we are not going to be able to deliver the services. It seems to me that, going from decade to decade, we are continually in a state of either having too many, too few or too many particular types of doctor and so on. Can you perhaps just outline the crux of the problem with the shortage of doctors?

[54] **Lesley Griffiths:** There are some specialties that we have recruitment problems with and there are some areas of Wales that we have very specific recruitment problems with. It is not just Wales; it is the UK. Health boards work on a six-year cycle to forecast what doctors they need, how many doctors they need and which specialties they need, and they have to work very closely with the Wales Deanery. You are absolutely right; if we had all the money in the world, if we do not have the doctors, we cannot provide the services. As I say, it is not all specialties; it is only some and it is not all over Wales. Obviously, the further west you go, you seem to have more problems. It is very important that our workforce forecasting is spot on, and it is very important that the deanery works very closely with health boards. That work does go on, but we have an issue with several specialties, as we have seen with Neath Port Talbot. It is a huge concern and I have to say that when clinicians engage with me about the difficulties the NHS faces, that is the one that they always highlight to me.

[55] **Mick Antoniw:** The problem with that, Minister, is that it does not actually tell me what the crux of the problem is or what you are actually doing about it. I understand everything in terms of recruitment, but that is very much after the stable door has been shut. Looking ahead six years, 12 years, or whatever, is it the case that our forward planning is not working, that we are not training enough doctors, and that we do not have enough specific links or tie-ins with doctors as they train, because this is a long programme? Are we not properly planning in certain areas? It seems to me that we are continually chasing our tails on this.

[56] **Lesley Griffiths:** The issue about tying in is certainly important and one aspect of the medical recruitment campaign is to encourage people who are training in Wales to stay in Wales. We provide accommodation for foundation doctors, which England does not, and we have a lot to be proud of in Wales. That is one part of the recruitment campaign that we need to focus on: are we training enough? You are right that we need to make sure that that workforce planning is there. In medical education I work closely with Leighton Andrews to make sure that we are training enough. Perhaps Chris will say a bit more about this.

[57] **Dr Jones:** I think that good doctors want to go to areas where they can receive good training, and the Neath Port Talbot example is perhaps a good one, because for some considerable time there has not been a full acute medical intake. There has not been acute surgery in Neath for some time, so quite a number of acute medical conditions cannot go there—more latterly, heart attacks and strokes do not go there. Over some time, we have recognised that it is not a place that provides adequate training in general medicine, and so it is not surprising in that situation that people do not want to go to that type of service. It is a strong driver for the service reconfiguration discussions because reorganising services so that they provide not only excellent services for patients, but excellent training opportunities for excellent doctors is a very important part of the forward-looking approach. The other problem with a service that perhaps does not have layers of doctors is that doctors report inadequate supervision, or feel that they are working at the limits of their competence. So, we have to

provide really secure arrangements for excellent doctors.

[58] **Lesley Griffiths:** Another issue is that doctors are not generalists so much these days. When I became Minister for Health and Social Services, I was shocked the first time that I went to an orthopaedic department to find that there was an orthopaedic surgeon who just operated on toes, literally. I had no idea that health had changed so much in that way—that we have orthopaedic surgeons who only operate on toes. That is part of the service reconfiguration, that we cannot provide every service in every hospital in Wales.

[59] **Mr Sissling:** The other point is that we need to look at the issue of sustainable medical staffing levels in the context of the broader clinical workforce. There are aspects where nursing, pharmacy and other professions can play a significant role. Of course, we need to be determined and look at the medical challenges, but there are also areas, looking at the broader clinical workforce, that are very helpful. We need to keep those in mind as well.

[60] **Mick Antoniw:** My final point on this is that, if you want to be a pilot in the RAF you get a grant early on, you get directed, you get supported, and there is a certain amount of commitment and so on. I hear a lot of 'we need to', but what exactly is going to change for the future? Will you actually be producing any form of report that specifically deals with the issue of doctors, retention, specialisms, and so on? My concern is that we seem to be going round in circles; we all know the problem, but we do not seem to have a strategy for the future to deal with it.

[61] **Lesley Griffiths:** We are working with the deanery, and I think that the deanery accepts that we need to do more. The medical recruitment campaign will have a positive effect. Certainly, we have some very good clinicians who are very happy to go out there and be champions for medicine in Wales. From here, I am going to an awards event for the NHS, and we need to keep showing what we do in Wales. In fact, I think that the UK system in England will help us to recruit doctors, and we will make the most of that. We are seeing the changes over the border in England and we know from the survey that was done that doctors prefer to practise medicine in Wales, so I hope we will be able to recruit from there. As to whether we will publish a report, I would certainly like to see a valuation of the medical recruitment campaign. In the work that I am doing with Leighton Andrews on medical education, we will expect to see better outcomes there. I have regular updates from the deanery, and I am very happy to report on that.

10.30 a.m.

[62] **Dr Jones:** I should also let you know that the chief medical officer has just established a medical and dental academic board for Wales that brings together all the medical schools, the clinical schools and the postgraduate deanery, and that is having its first full meeting this Friday. It will be looking at workforce issues in the round as well. However, I suggest that one should not underestimate the significance of the service reconfiguration work in terms of improving the attractiveness of Wales to doctors.

[63] **Mark Drakeford:** I will go to Elin next, then William, then Lynne.

[64] **Elin Jones:** I have four areas that I want to ask you about, Minister. Is four too many?

[65] **Mark Drakeford:** No, go on.

[66] **Elin Jones:** First, I do not want to start a debate with you about what a hospital downgrade is; for me, removing a service from a hospital makes it a hospital downgrade. That is how I see it. I accept the point that you made to—I have forgotten your name.

[67] **Darren Millar:** Darren. [*Laughter.*] It is easily done.

[68] **Elin Jones:** Thank you. If the service is unsafe, then it needs to be changed or removed until it is safe. Bronglais adult mental health ward was closed by Hywel Dda health board yesterday, or the day before, and moved to Carmarthen. Temporarily, I would accept that, but if it is a permanent removal then that is different, because you can plan things differently in terms of recruitment and placing staff to create a safe service. Is it your expectation that a permanent removal of service always requires a full public consultation?

[69] On the Wales Deanery and the training reconfiguration that seems to be happening there—and its influence on hospital reconfiguration in Neath Port Talbot is an example—have those training changes been agreed with you?

[70] Thirdly, on the financial matters, you have said that you have balanced plans from six of the health boards. Last financial year was characterised by the last quarter being about the closure of community hospitals and minor injuries units in order to deal with end-of-year finances. On 1 April a number of those units or hospitals reopened. Next year, will this financial year feel the same, with health boards making temporary closures or service reductions? Is that part of the balanced plans that you have referred to?

[71] Finally, on substance misuse, I had not realised until I read your paper that you had taken over responsibility for that. There is an issue that I had been pursuing with the Minister who had responsibility for substance misuse previously, and I will now be able to pursue it with you, and that is residential rehabilitation for substance misuse. The latest figures that I have show that 50% of placements from commissioners in Wales go to residential rehabilitation homes in England. Do you agree that it should be a priority, if places are available in Wales, that they are commissioned in Wales?

[72] **Lesley Griffiths:** To start with your last question, the responsibility for tackling substance misuse came into my portfolio from 1 April. It was something that I was picking up as I went around Wales, people would ask me questions, and I would be saying, ‘That is not in my portfolio’, and it should be, I felt. I then had a conversation with the First Minister and with Carl Sargeant and now it is with me. Yes, I agree that, if at all possible, we should offer placements in Wales. It is better for the patient and much more efficient. My immediate priorities in relation to substance misuse are to finalise the new three-year action plan, which supports the implementation of the substance misuse strategy, ‘Working Together to Reduce Harm’. Certainly, the issue of placements is something that I am looking closely at.

[73] Going back to finance, I do not agree that the last quarter was characterised, on balance, by closures and so on. Certainly, a lot of the efficiency savings made by LHBs were on recurrent services, and I will bring David in again on that. On your question on the deanery, you are talking about core trainee 2 doctors, and they felt that they were not getting the supervision that they needed, and they did not get the input. That was a decision for the deanery, which it took, and as I said in the Chamber yesterday, I have a certain amount of sympathy with that. If we want to recruit and keep doctors, we have to make sure that they get the training that they require.

[74] In relation to permanent removals, obviously there is an obligation to go to the community health council and it then decides whether it goes to public consultation. Hopefully, the service reconfiguration will address this now. I do not want to see what we saw on Friday, and the health board has said the same—it is a shame that it had to do this. However, I cannot support unsafe services, and I know that nobody around this table would support unsafe services. I am sorry that those services had to be removed at this time, when they are drawing up the reconfiguration plan.

[75] **Dr Jones:** May I just make a comment about the role of the deanery? There is a danger in thinking that the deanery makes these decisions in an arbitrary fashion, almost on a whim, but it has very serious responsibilities to the General Medical Council to ensure that doctors get proper training. That is something that matters to us greatly in the round. The deanery is simply meeting its responsibilities in providing us with the advice that we need, and we welcome that. As I say, it is recognised as a very good deanery.

[76] With regard to the downgrading of hospital services, the focus on hospitals is really unhelpful, and is one reason why I could not answer the question earlier. I just do not think about services in terms of hospitals; I think about them in terms of people. It is about what the person gets: do they get prompt care from the right person at the right time in the right place to get the best possible outcome? To me, it matters not whether that happens in a primary care resource centre or a major teaching hospital or a smaller hospital, so the conversation about hospitals is really unhelpful. The word ‘downgrading’ is often used to say that everything must stay the same forever, but we have seen, even from what was happening last week, that we have services that are becoming unsafe if they stay as they are forever. So, this is an improvement in the quality of care for individuals.

[77] **Lesley Griffiths:** However, I also recognise that people are very attached to their hospitals, and we have to take that on board.

[78] **Elin Jones:** It matters not to me either whether the service is in a hospital or another establishment. What matters to me is that there is no 24-hour emergency mental health provision now available to the Aberystwyth community. That is important, whether it is in a hospital or another situation. Do not tell me that I am obsessed with hospitals; I am obsessed with the care that is available for the individuals in any community.

[79] **Mark Drakeford:** Darren wishes to come in on this point, briefly.

[80] **Darren Millar:** Yes, if I may, I had a question on finances. You referred earlier on, Mr Sissling, to the fact that the plans this year for the £315 million of savings had been prepared and given to the Welsh Government. Do those plans assume certain outcomes from consultation on service reconfiguration? If so, will you publish those plans? I assume that they do.

[81] **Mr Sissling:** I have a couple of points. First, to respond to that specific point, I should make it clear that the temporary closure of some facilities in the last quarter of last year was driven by staffing issues and meeting demand at times when there is a peak, particularly in non-elective care. Some decisions were made to temporarily close some facilities and transfer the staff into other facilities. That was not for financial reasons—it was to make—

[82] **Elin Jones:** Miraculously, they all reopened on 1 April.

[83] **Mr Sissling:** I am just explaining my professional understanding of the position. The financial plans of the health boards have been shared with their boards—they are shared in public, open meetings, which means that they are available to anybody who has an interest in the plans. The extent to which they are dependent or reliant on a series of different things would be clear within the plans. The extent to which they are in any way dependent on the outcomes of the consultation would be very limited, because of the time frames involved. This is because they will be consulting through the summer into autumn, and clearly, there is an important process at the end of the consultation to take stock of the responses and then to come to decisions, and the degree to which the balanced plans, which we have explained that in existence this year, are dependent on the outcomes of those in any direction is extremely

limited.

[84] **Darren Millar:** To be clear, they assume certain outcomes from the consultation processes that are likely to happen over the summer, do they not?

[85] **Mr Sissling:** To a very small extent, there may be some that will have some expectation of outcomes. I suppose that the question behind that is whether this is the issue that delivers the £300 million of savings. It is not; it is work that had already started and was in train, and it is work that will continue through the coming months.

[86] **Darren Millar:** Just as a point of clarification—

[87] **Mark Drakeford:** The very last one.

[88] **Darren Millar:** It is very important, because a statement has just been made that suggests that none of the emergency closures of things like minor injuries units over the winter period last year were based on financial pressures. Of course, Betsi Cadwaladr University Local Health Board specifically said that one of the pressures was financial, and that was one of the reasons it withdrew services from certain hospitals.

[89] **Mark Drakeford:** I want to add one question to that, although I am keen to get to William and to Lynne. Minister and Mr Sissling, you have both refuted the suggestion that there were service closures in the last quarter of last year that were financially driven. However, if you look at the board papers of LHBs across Wales, I do not think that there is any doubt that there was a concentration of financial savings in the last quarter of the last financial year. For the first three quarters of the year, you see boards reporting that they are not making the savings needed and that they are behind the profiles that they need to reach to be in the position that the Minister required of them, and then, in the last quarter, there was an awful lot of ground to make up. Are you hoping that LHBs will offer you a more gradual approach across the year to realising the savings that they need to find in this financial year?

[90] **Lesley Griffiths:** Absolutely. I think that that is one of the problems of their having to come in on balance on 31 March every year—it is very difficult to do so. However, I think that the new financial regime that is coming in will certainly help them to do that. It is a very important point.

[91] **Mr Sissling:** I concur entirely that we are very much pressing the health boards to have a smoother trajectory of savings through the year. The reliance on savings in the final quarter is not in line with the best way of managing it. Some will be a little bit back-loaded, because some preparatory planning time is necessary, but we want to see a delivery that shows that they are on track as much in June as they would be at the end of February. It is very much where we are at the moment.

[92] **William Graham:** Minister, I want to ask about the ambulance service with regard to note 71 in your paper. It is probably worth saying that previous Ministers and directors of the service have improved that service considerably, taking the workforce with them, which in itself is an achievement. It was previously identified that one of the problems is not necessarily with the service itself, but with the relationship with hospitals. Are you confident that the partnership can improve? Clearly, there is a great deal of scope for improvement in the handover, just to give one example.

[93] **Lesley Griffiths:** Yes, and it is something that is always on my agenda with the chairs, whom I meet every four to six weeks. The handover time in particular is very important, and when I do my spot checks at hospitals, it is always the first place I go, to see how many ambulances are outside. The last time that I went to Glan Clwyd on an

unannounced visit, there were none, which was very good to see. I pass the Maelor hospital a lot and I check it out. I think that it is very important and it is something that we are focusing on.

[94] We have set up an unscheduled care board, which has been in operation for about two months.

10.45 a.m.

[95] **Mr Sissling:** It has met twice.

[96] **Lesley Griffiths:** It has met twice, and this is one issue that we are looking at. The relationship between ambulances and LHBs is important, but there is always room for improvement and it is something that we are focusing on. The Welsh Ambulance Services NHS Trust consistently meets the 65% all-Wales target for responding to category-A calls, but the handover target is the one that I am most disappointed in. I have said that there must be a huge amount of work done on it. It is one of the reasons that we set up the unscheduled care board.

[97] **William Graham:** May I encourage you in another way? Clearly, there will be times when ambulance response times fail for perfectly legitimate reasons. Could I therefore encourage you to encourage the service to give a more definite reply to people? There are always headlines about people who have waited for three hours and all the rest of it, but the usual response is to say that an investigation will be held. Now, the public are not stupid. The service should respond by saying that all the ambulances were engaged, or that there were staff illnesses or other reasons that are transparent, rather than a bland excuse that does not build confidence. Can you do that?

[98] **Lesley Griffiths:** Certainly. I will speak to the chair of the ambulance trust about that. I have done a great deal of work over the last year to ensure that the trust deals with complaints in a better way. I myself met a family last week, with your colleague Nick Ramsay—it was a very difficult case, but it is important that I know what is going on, so that I can pass it on to the ambulance trust and make sure that it is dealing with it well.

[99] It is also about educating the public to make sure that people do not ring for an ambulance when it is not necessary—they are emergency vehicles, and the fact that they have gone through this new clinical response is going to help in that way.

[100] **Dr Jones:** Perhaps I could add that the Welsh Government has a part in ensuring that active learning and change happens when things go wrong. Like other organisations in the NHS, the ambulance service has to report to us any serious incidents that occur. We then require the service to investigate those incidents and we require knowledge of what actions have been taken before the matter is closed. It is a slightly separate point to that of public transparency and communication, which is also important, but we do play a part in ensuring that change happens when things go wrong.

[101] **Lynne Neagle:** I want to go back to the £315 million for my first question. Clearly, it is a significant sum of money, and the Minister's paper says that the financial plans will be subject to intense management scrutiny. What scrutiny and monitoring will there be throughout the year at Welsh Government level of the delivery of those plans? In particular, what steps will the Welsh Government take to ensure that the savings are not made through things like cancelled operations and reductions in patient care?

[102] On orthopaedics, your paper notes the improvement that there has been. Obviously, we have had significant extra investment in orthopaedics, and I want to know if you are

satisfied that we are now on track throughout Wales for delivery in orthopaedics.

[103] Finally, on the individual patient funding request process review that you have undertaken since your previous appearance at the committee, what specific changes will result? Have you made any further progress in relation to the publication of data on IPFR applications?

[104] **Lesley Griffiths:** Let us start with that one first. The review of the individual patient funding request process that you referred to highlighted a number of issues that needed to be addressed. One of the main ones was consistency between panels, along with workloads for clinicians, the transparency issue, to which I will come back, and improving how decisions taken by the panel are relayed to the patient.

[105] I have commissioned the Welsh medicines partnership, which provides executive support to the all-Wales medicines strategy group to provide fast-track guidance on new medicines that have not been appraised either by National Institute for Health and Clinical Excellence or by the group, and that will draw together all available advice and allow panels to better identify exceptionality, because that was an issue before we had the review. I also think that it will help with consistency of approach. For instance, it was done with abiraterone—you will be aware that that was appraised by the group before NICE.

[106] Certainly, I want to see as much information published as possible, and I mentioned it to the chairs at the meeting a fortnight ago. I told them that the information has to be published. The health boards are also looking at how the information is communicated and at the possibility that clinicians could need further training in this area.

[107] You mentioned orthopaedics, and yes, I do think that we are now on track. The additional £63 million that my predecessor brought in was not used just for waiting-list initiatives; it has been used, for instance, to put musculoskeletal services in place, to make services much more sustainable so that we do not have that issue again.

[108] Finance is monitored monthly. My first meeting of the day was with my director of finance, and he meets the directors of finance for each LHB monthly. You meet with the chief executives monthly, David. That is how it is monitored.

[109] **Mr Sissling:** We undertake a process, which started before the start of the financial year, planning plans for this year and three-year plans that show how they can flow through into following years. We risk assess the plans, and then we have a monthly profile of delivery. By the end of this week, for example, we will have the results for last month, and we will have discussions with health board chiefs and trust chief executives collectively about common issues and individually if there are issues of particular concern. As a matter of good practice, we are looking at quarter 1 results, which is significant, and I and the director of finance for the NHS in Wales are meeting with each of the chief executives and directors of finance for each health board individually to ensure that there is an appreciation of any important issues where action is taken.

[110] It is really important to say that we do not look just at the finance in those discussions. We look at all other areas of performance. Finance is just one in a whole series of things in our delivery framework, so we need to make sure that we are delivering equally in unscheduled care, planned care and on the important quality measures such as pressure sores, healthcare-acquired infections and mortality rates. We look at all aspects to make sure that they are delivering in all areas that are important.

[111] **Mark Drakeford:** Kirsty, do you want to come in on this point?

[112] **Kirsty Williams:** I want to go back to the issue that Lynne Neagle raised about access to medicines. Whatever people think of the process, we do have a process currently and the Government is doing its best to make it as open and transparent as it is in terms of access to medicines, which can be a really difficult subject for people. It seems to me, however, that we do not necessarily have a process for dealing with new medical technology, which could be appraised and brought into Wales perhaps sooner than it is at present. Does the Government have any plans to introduce a similar procedure for the testing and assessment of new medical technologies so that the very latest interventions outside drug and medicine therapies are introduced in Wales?

[113] **Lesley Griffiths:** We have the Welsh Scientific Advisory Committee. That looks at new technology.

[114] **Dr Jones:** It is a very important topic. In terms of excellence of care, and a modern healthcare system that attracts the best doctors and other healthcare professionals, it is really very important. I do not think that we would ever have the capacity in Wales to undertake full technology reviews to the level that NICE can. NICE does undertake technology appraisals, which we recognise and try to implement.

[115] The issue of medical technology crops up in many different places in NHS Wales. The Welsh Scientific Advisory Committee will review a number of new technologies and provide advice to us about that. The various national specialty advisory groups will also have an interest in giving us advice on new technologies in their specialty areas. I chair a cancer implementation group, for instance, which has all the executive directors responsible for cancer to provide strategic leadership, and, on our next agenda, we have CyberKnife.

[116] So, a lot of work is going on to keep aware of new technologies and to do our best to implement them. The Welsh Health Specialised Services Committee also has a significant role in this, and it will do quite a lot of work on the basic evidence in relation to new technologies, because in many respects it commissions them. So, there is a lot of work going on, and it is a very important topic. I think that we need to draw all these different elements of work together, so that there is an identifiable framework that is easily recognisable, because there is more going on than people realise.

[117] **Kirsty Williams:** If something is cropping up in lots of different areas, is there scope to bring all of this together so that there is a clear pathway for clinicians and people with an interest in this area, so that they know how these things are dealt with by Welsh Government?

[118] **Dr Jones:** There is the issue of drawing it all together so that there is an identifiable framework, but I do not think that there should be one place, just because of the different range of skills and experience that would be needed to provide advice. The cancer and radiotherapy-type work is different from the cardiology-type work and so on. So I think that it is reasonable that it happens in different parts of the NHS, so long as we can understand how it happens.

[119] **Mark Drakeford:** It is worth mentioning to the Minister that it is likely that the committee will spend a bit of time on this topic in the autumn to look at how things are done now and how they might be done better in the future. Lynne, did you want to follow up on the answer that you had earlier?

[120] **Lynne Neagle:** On IPFR, you said that you had told the chairs that you expected to see this information made public. Does that mean that you will publish the information on a health-board basis?

[121] **Lesley Griffiths:** Yes.

[122] **Lindsay Whittle:** Most of the questions that I wanted to ask have already been asked and answered, but we will clearly be facing a huge shortage of GPs in the future—I read a report on this somewhere—particularly in some of our Valleys’ communities, because so many GPs are retiring. So, are we, for example, going to the healthier countries of the world where I understand there is a bit of surplus of doctors and nurses—I am thinking of Canada, Germany and possibly even Cuba, although there may be issues there—to try to encourage some of those doctors to come here? We are clearly not training our own. I read some years ago about a young man in this city who achieved at A-level four A*s or A plusses or whatever they are called these days, who wanted to go into medicine, but was in fact refused a place. You cannot get higher qualifications than those that young man had to work hard to obtain. He decided to become a vet instead. There is no comparison in training someone to treat Tabby the cat as opposed to Taffy the Welshman. [*Laughter.*] So, what are we doing? I like cats—I have a cat—but what are we doing to get some of these healthier countries to encourage their doctors to come here?

[123] **Lesley Griffiths:** I always enjoy Lindsay Whittle’s questions in committee. At the moment, we do not have a problem with GP recruitment in Wales, but you are right in that I think that it was the British Medical Association that highlighted to me that the number of GPs in Wales over the age of 50—which, of course, is not old—is quite high.

[124] We are looking abroad. I am not quite sure about Cuba, but we have certainly looked to countries like Dubai. There has been recruitment in Dubai. It fits in with our medical recruitment campaign, I suppose. It is about ensuring that people realise that Wales is an attractive place to come to practise medicine. It is about encouraging people with four A-levels to think about medicine as a career. I am not saying that being a vet is not a very good career, because it is, but it is about encouraging that. I cannot comment on specific examples, obviously, but I would hope that if someone had four A-levels in the correct subjects and wanted to do medicine, they would certainly be encouraged to do so.

[125] **Mick Antoniw:** You referred some time ago to immigration problems in terms of visas. Are those resolved now or do those problems continue?

[126] **Lesley Griffiths:** No. When I last spoke to the General Practitioners Committee Wales, that was still an issue.

[127] **Mark Drakeford:** Diolch yn fawr **Mark Drakeford:** Thank you all very much iawn i chi i gyd am ein helpu’r bore yma. for helping us this morning.

[128] The hour went quickly, but I hope that we managed to cover most of the topics that Members wanted to raise. Once again, thank you to all of you for your answers.

10.59 a.m.

Papurau i’w Nodi Papers to Note

[129] **Mark Drakeford:** Mae cofnodion y **Mark Drakeford:** The minutes of the pwyllgor ar 20 Mehefin i’w nodi. A yw pawb committee on 20 June are to be noted. Is yn hapus gyda’r rheini? Gwelaf eich bod. everyone happy with those? I see that you Byddwn yn cyfarfod yr wythnos nesaf. Dyna are. We will be meeting next week. That ddiweddd ein cyfarfod am heddiw. concludes our meeting for today.

*Daeth y cyfarfod i ben am 10.59 a.m.
The meeting ended at 10.59 a.m.*

