Cynulliad Cenedlaethol Cymru
Y Pwyllgor Archwilio

The National Assembly for Wales
The Audit Committee

Dydd Iau, 6 Gorffennaf 2006
Thursday, 6 July 2006

Cynnwys
Contents

3 Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

4 Archwiliad Ariannol o Lywodraeth Ganolog a Chyrff y GIG yng Nghymru: 2006
Financial Audit of Central Government and NHS Bodies in Wales: 2006

22 Amseroedd Aros y GIG: Adroddiad Dilynol
NHS Waiting Times: Follow-up Report

37 Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio ar Ariannu Gardd Fotaneg Genedlaethol Cymru
The Welsh Assembly Government Response to the Audit Committee Report on Funding the National Botanic Garden of Wales

37 Adroddiad Diweddaru ar Gaffael yn y Sector Addysg Uwch yng Nghymru
Update Report on Procurement in the Higher Education Sector in Wales

38 Adroddiad Blynyddol 2005-06 y Pwyllgor Archwilio i'r Cyfarfod Llawn
Audit Committee’s Annual Report to Plenary 2005-06

38 Cofnodion y Cyfarfod Blaenorol
Minutes of the Previous Meeting

38 Cynnig Trefniadol
Procedural Motion

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau o’r Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Mick Bates, Jocelyn Davies, Mark Isherwood, Denise Idris Jones, Christine Gwyther, Catherine Thomas.

Swyddogion yn bresennol: Christine Daws, Cyfarwyddwr, y Gyfarwyddiaeth Adnoddau; Ian Gibson, Dirprwy Swyddog Cydymffurfiaeth, Cynulliad Cenedlaethol Cymru; John Hill-Tout, Cyd-gyfarwyddwr, y Gyfarwyddiaeth Perfformiad a Gweithrediadau, yr Adran Iechyd a Gwasanaethau Cymdeithasol; Ann Lloyd, Pennaeth yr Adran Iechyd a Gwasanaethau Cymdeithasol; David Powell, Swyddog Cydymffurfiaeth, Cynulliad Cenedlaethol Cymru; Peter Ryland, Prif Gyfrifydd, Cynulliad Cenedlaethol Cymru; Syr Jon Shortridge, Ysgrifennydd Parhaol, Cynulliad Cenedlaethol Cymru

Eraill yn bresennol: Gillian Body, Swyddfa Archwilio Cymru; Jeremy Colman, Archwilydd Cyffredinol Cymru; Geraint Morgan, Swyddfa Archwilio Cymru; Rob Powell, Swyddfa Archwilio Cymru; Mike Usher, Swyddfa Archwilio Cymru.

Gwasanaeth y Pwyllgor: Kathryn Jenkins, Clerc; Dan Collier, Dirprwy Glerc.

Assembly Members in attendance: Janet Davies (Chair), Leighton Andrews, Mick Bates, Jocelyn Davies, Mark Isherwood, Denise Idris Jones, Christine Gwyther, Catherine Thomas.

Officials in attendance: Christine Daws, Director, Resources Directorate; Ian Gibson, Deputy Compliance Officer, National Assembly for Wales; John Hill-Tout, Co-director, Performance and Operations Directorate, Department of Health and Social Services; Ann Lloyd, Head of Department of Health and Social Services; David Powell, Compliance Officer, National Assembly for Wales; Peter Ryland, Chief Accountant, National Assembly for Wales; Sir Jon Shortridge, Permanent Secretary, National Assembly for Wales.

Others in attendance: Gillian Body, Wales Audit Office; Jeremy Colman, Auditor General for Wales; Geraint Morgan, Wales Audit Office; Rob Powell, Wales Audit Office; Mike Usher, Wales Audit Office.

Committee Service: Kathryn Jenkins, Clerk; Dan Collier, Deputy Clerk.

Dechreuodd y cyfarfod am 1.33 p.m.
The meeting began at 1.33 p.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

[1] **Janet Davies:** Prynhawn da. Croeso i aelodau’r pwyllgor a’r cyhoedd i’r cyfarfod.

Janet Davies: Good afternoon. I welcome committee members and the public to the meeting.

[2] I remind everyone that the committee operates bilingually, and that headsets are available for the translation of Welsh into English, as well as to amplify the sound.

[3] Atgoffaf bawb i ddiffodd eu ffonau symudol, *pagers*, neu unrhyw ddyfais electronig arall, gan eu bod yn ymyrryd â’r offer cyfieithu a darlledu. Os bydd rhaid gadael yr ystafell mewn argyfwng, dylid gadael drwy’r drws agosaf atoch a dilyn

I remind everyone to switch off their mobile phones, pagers, or any other electronic device, as they interfere with the translation and broadcasting equipment. If we have to leave the room in an emergency, you should leave via the nearest exit and follow the

cyfarwyddyd y tywyswyr. ushers' directions.

[4] I have had apologies from Alun Cairns and I also understand that Carl Sargeant and Irene James will not be attending. Christine Gwyther will substitute for one of them. Do any Members need to make a declaration of interest? I see that you do not.

1.34 p.m.

Archwiliad Ariannol o Lywodraeth Ganolog a Chyrff y GIG yng Nghymru: 2006
Financial Audit of Central Government and NHS Bodies in Wales: 2006

[5] **Janet Davies:** We now move on to the Auditor General for Wales's 2006 report on the financial audit of central Government and NHS bodies in Wales. The report summarises the findings from the financial audit work of the auditor general on the 2004-05 accounts. This year, for the first time, the auditor general's report also reflects his role since April 2005 as the external auditor of NHS bodies in Wales. This enables his findings to cover a broader spectrum of public sector activity. It is a welcome development, and also means that this committee can more comprehensively consider the cross-cutting themes, issues and best practice identified by the auditor general's financial audit work.

[6] The main areas of the report that we will be considering today are matters arising from the audit of the 2004-05 accounts, financial and risk management at audited bodies, how the requirements of the Freedom of Information Act 2000 are being addressed and aspects of the Assembly Government's recent structural reforms. The report, by convention, does not normally disclose the names of individual organisations, but we will look to see what important issues have a wide-spread application that needs to be brought out from its findings.

[7] Therefore, we are taking evidence today from Sir Jon Shortridge, the Permanent Secretary of the National Assembly for Wales, and from Mrs Ann Lloyd, the director of NHS Wales. Each of them has an official with them. I ask you to introduce yourselves for the Record, please. In addition—I should have said this before—please do not touch your mikes; they are slightly temperamental, and we must not touch them.

[8] **Sir Jon Shortridge:** I am Jon Shortridge, the Permanent Secretary.

[9] **Ms Lloyd:** I am Ann Lloyd; I am the Head of the Health and Social Services Department and the chief executive of NHS Wales.

[10] **Dr Daws:** I am Christine Daws, the director of resources at the Health and Social Services Department.

[11] **Mr Ryland:** I am Peter Ryland, the Chief Accountant.

[12] **Janet Davies:** Thank you. As usual, I will start. Paragraphs 3.1 to 3.13, refer to the Assembly's new structural reforms and accountability arrangements. My question is to Sir Jon Shortridge. Structural reforms took a significant step forward on 1 April, when a number of former Assembly sponsored public bodies came into the Assembly. How well do you think that this process has gone and have you had time, as yet, to see whether there are any emerging issues?

[13] **Sir Jon Shortridge:** I distinguish between what I call the transition to the new, enlarged Assembly Government on the one hand, and the success of the mergers on the other. So, the transition effectively took place on 3 April and the week following that, and, in my judgment, it was fairly successful. I qualify it a bit, but it was a huge achievement for all

concerned—we are talking about 1,600 staff from four different organisations effectively coming into an enlarged organisation overnight. The organisation had to be on a common financial system and other systems and it immediately had to be able to conduct business in exactly the same ways. There have been no adverse public comments, so, at one level, that indicates that it was a successful transition, and, as I said, it is a huge achievement for all those who were involved in making it or affected by it.

[14] I think that the second half of your question was, essentially, how it is going. Is that right?

[15] **Janet Davies:** Yes, as far as you have had time to see.

[16] **Sir Jon Shortridge:** It really is too early to say, at one level. The view that I have taken is that successful mergers, which means having the two new departments operating successfully, by definition will take six to 18 months. We need those new departments—in one case, that is 1,500 people plus—to have established their new culture and their new working arrangements, and to have taken full benefit from the mergers. I do not think that one can expect to see full success for, as I said, six to 18 months. We are at a critical stage, at the moment, as we are halfway through the first six months. You can almost say that the euphoria of the initial success of the transition is wearing off. There are certain teething problems in terms of the internal administration—I am not talking about the outward performance. Those are things that I have identified from my trips around offices in Wales. I am vigilant about ensuring that those issues are being dealt with, and that the staff who are affected are informed of how we are dealing with them. In summary, I would say so far so good.

[17] **Janet Davies:** Comments have been made about the morale of the organisations that have come in. Are these internal teething problems having any effect on their morale, or are they things that they accept that are bound to happen?

1.40 p.m.

[18] **Sir Jon Shortridge:** I am very disappointed when I hear unsubstantiated comments about morale within parts of my organisation. I can only speak from my own personal experience and I have spent quite a lot of time talking to the staff affected, particularly in north Wales, where you think there might be a double morale problem in that they could feel disassociated from what is going on in Cardiff, in addition to the fact that they have come into an enlarged organisation. I have also spoken to staff in Cardiff. I have been incredibly impressed at the positive attitude of virtually all the staff that I have spoken to, and I have been even more impressed at the quality of the skills that they have and their commitment and determination to provide a service for Wales. One should not be complacent about morale issues, but the key responsibility for addressing those issues in the two new departments lies with the heads of those departments and I have great confidence in the way in which they are performing at the moment.

[19] **Jocelyn Davies:** It is possible that morale could be affected without you knowing about it, but are you quite happy to say that you are not aware of any evidence that there are widespread problems with morale?

[20] **Sir Jon Shortridge:** I am talking about my own personal experience from talking to the staff concerned. When I talk to staff, I encourage them to be very open with me. I think that I indicated in my answer that there were some pockets of staff who were less happy about the situation than others; in particular, that includes staff who have central-service roles, where their position is more ambiguous as they move into a larger organisation, because a lot of them then have to be integrated with existing central services and therefore move away from the new department that was their old organisation. There are issues, and I would not

want to suggest that there are not, but, overall, my impressions are very positive.

[21] **Janet Davies:** Turning to a different topic in the same area of the report, you recently appointed sub-accounting officers. Do you think that those arrangements are bedding in well? Will you have to make any other changes to the Assembly's financial management structures?

[22] **Sir Jon Shortridge:** On the sub-accounting officers, I think that the new arrangements are operating well. I did that in a careful and proportionate way. Before I appointed individual heads of department as sub-accounting officers, I had to be satisfied that they were properly ready. They did their own self-assessment for me, which was moderated by internal audit. So, I am satisfied that the way in which they took over their responsibilities was robust. They all have their own corporate governance committees on which an internal audit unit and Wales Audit Office representative sits. I receive quarterly reports from those corporate governance committees and all the evidence that I have at the moment suggests that this is a significant improvement on what we had before. The main improvement for me is that I have dispersed more widely the personal responsibility that goes with being an accounting officer. I had to rely on these people in the past, before they were sub-accounting officers, to exercise my accounting officer responsibilities on my behalf, but they did not have the personal responsibility that went with it. I have given them that personal responsibility and I think that that sharpens up the quality of accountability within their parts of their organisation.

[23] In terms of what other financial management improvements may take place in the future, I never really rest on financial management issues and I am always looking for ways in which we can make improvements. Some of those may emerge under other questioning, but I have nothing in mind at the moment of the same scale and significance as the creation of sub-accounting officer roles.

[24] **Leighton Andrews:** Sir Jon, I am sure that we are pleased to see that the Treasury awarded the Assembly its most improved organisation award. I will pick up on a couple of points in figure 2 of paragraph 2.4 about further improvements in the quality of accounts that are seen to be required. These will obviously need to be implemented in the context of faster closing times by the Treasury. Are you geared up for that?

[25] **Sir Jon Shortridge:** How do I see faster closing going?

[26] **Leighton Andrews:** Are you geared up for delivering the further improvements that are required in the context of faster closing?

[27] **Sir Jon Shortridge:** On progress so far with the 2005-06 accounts, we submitted our draft core account to the Wales Audit Office for audit just about on time—the Estyn element of it was a week late. We were conscious that, in submitting it, one or two gaps needed to be filled. However—and the auditor general may wish to comment on this—in general terms, we submitted it sufficiently on time for the audit office to be able to do its work, and for us not to be holding it up at all. Therefore, it is so far, so good for this year.

[28] I have monthly meetings with my accountants, throughout the year, on the preparation of the accounts, and then the learning that you take from the account process. Therefore, the intelligence that I have from my accountants is that, at present, they can see no impediment to their delivering the closing deadlines for this year. For example, that means that we have to have the consolidated accounts to the Wales Audit Office on 17 August, and signed on 24 August.

[29] For next year, we essentially have to bring that deadline forward by a fortnight, which will impose further demands on us. One thing that we may come to is the introduction of the

accrual accounting system, which I want to introduce by the end of this calendar year; that should assist us with that faster closing for the 2006-07 accounts. Therefore, generally, we are on course.

[30] **Leighton Andrews:** Will you also be able to meet the conditions of the requirements specified in figure 2, in terms of the quality of the accounts and the other improvements that are recognised there?

[31] **Sir Jon Shortridge:** Are you referring to the last segment of figure 2?

[32] **Leighton Andrews:** A series of issues remain, including grant monitoring, and so on, but, yes, it is the complete documentation, and so on.

[33] **Sir Jon Shortridge:** These are the requirements on us, which I expect my accountants and the people on whom they rely to meet. I have no reason to suppose that we shall not be compliant with any of that.

[34] **Leighton Andrews:** Are you satisfied that the final accounts of the former Assembly sponsored public bodies have been prepared on time, and are of good quality?

[35] **Sir Jon Shortridge:** Yes. I do not have information on that in front of me, but I have no reason to suppose that the final accounts of the ASPBs have not been prepared on time. We need them in order to meet our wider requirements in relation to the consolidated account. To the best of my knowledge—and I will bring in Peter to confirm this—those have all been completed satisfactorily.

[36] **Mr Ryland:** I would not add much to that. The accounts have been prepared, substantially, on time. I am in regular contact with Mike Usher’s team in the Wales Audit Office. We also use the resource accounting project board, as a point of contact within the sponsor department, so that we know what is happening in the ASPBs, and we are on track.

[37] **Leighton Andrews:** I will focus some more on figure 2. Sir Jon, one issue that is raised there is the control of grant expenditure, which is a problem that has concerned us in the past. Would it be true to say that there are still areas where there are not proper written financial procedures in place?

[38] **Sir Jon Shortridge:** I am not aware of a failure to have proper written financial procedures in place. Again, Peter may want to comment if he has knowledge of that, but I would be disappointed if that were the case. Grant management continues to be an issue of concern for me. In our last management letter, the WAO commented on that, but what it said—if I can summarise correctly—is not that there was any systemic problem with our grant management systems as a whole, but that there was a need to strengthen controls on some of our smaller schemes. In parallel with that, I had asked my internal audit unit to do a review of grant management—it reported in December, and it had some significant recommendations in its report in terms of the improvements that it expected to see, and I took that seriously.

[39] Going forward, part of the solution is the introduction of the e-grant system, which we are rolling out across the organisation. The system will be in place by December, and will be our accruals-based system for managing and controlling grant expenditure. However, I do not see that as the whole solution. In the longer term, I want to introduce a standardised grant system that is information-technology enabled, which can then be applied to every grant scheme that we operate in the Assembly Government. I think that greater standardisation, on a single IT grants platform, ideally, will drive up the quality of the service that we provide and give me greater assurance. However, that is a long-term project.

1.50 p.m.

[40] **Leighton Andrews:** Would it be possible to have a short note on what your internal audit team recommended?

[41] **Sir Jon Shortridge:** Absolutely; that is not a problem.

[42] **Leighton Andrews:** I will move on to asset management. Last year, you described to us what was being done in that particular area. Are you, through that process, ensuring that the useful lives of assets, or the risks of changes in value, are being kept under regular review?

[43] **Sir Jon Shortridge:** Are you talking about asset management within the Assembly Government or across the wider public sector?

[44] **Leighton Andrews:** I am talking about it within the Assembly, which I assume means a bit more than just the Government.

[45] **Sir Jon Shortridge:** I am still concerned that we are not giving as much attention to asset management issues as I would like to. When I spoke to you last year, I said that we were in the process of preparing a unified asset management plan for the whole of the Assembly. I am told that that plan is virtually complete, and I will be receiving it possibly as early as next week so that I can look at it and comment on it later this month. That shows that there is progress in terms of process, but because I have not had the opportunity to read it, to comment on it or to make my own evaluation of it, I cannot give you a full assurance in terms of the actual progress that we have made. However, I do know that, over the last year, we have completed a review of all our estate, which is quite big and diverse. Therefore, we have our estate strategy going forward, and I would expect the outcome of that work to be embedded in this asset management plan that I will be receiving shortly.

[46] **Leighton Andrews:** Okay. I guess that we might want to return to that. Mrs Lloyd, how well developed is asset management planning within the national health service?

[47] **Ms Lloyd:** The NHS has always been at the forefront of asset management, even back in the early 1990s, because of capital charging, which brought to a sharp focus the need to manage the assets well. As you know, we had little capital in Wales during those years. We now have a much-increased capital programme, and this committee has tested me, on at least two occasions, on the way in which we manage our estate, its depreciation and how we sell it. I am glad to say that, with the mergers, some incredibly excellent help has come from our new director of enterprises, who is lending his support and that of his staff to our being able to dispose of our surplus land and buildings in a more professional way than was the case in the past. Therefore, we have well-established capital investment procedures, and now that we have a large amount of capital to spend in a short time and many schemes that have been on the stocks for a long time, we have revised the capital investment guidance. We have also revised the way in which business cases will be managed and developed, and, as part of the capital expenditure, we have been investing in people who are experts in the field to help people to prepare those business cases and their estates plans. We have also taken a leaf out of England's book, in terms of a quasi LIFT scheme, for which we have preferred providers that manage the whole package for us and for the NHS. The estate plans and the assets registers have always been essential for us, particularly as we have capital charging in the NHS, so we have to ensure that we get value for money from our estate.

[48] **Janet Davies:** We will now turn now to payment performance.

[49] **Mick Bates:** I would like to start with page 12, and paragraph 2.8 and figure 3. You will see that in 2004-05, all 22 local health boards met the required standard of making 95 per cent of all payments within 30 days. Conversely, paragraphs 2.9 and 2.10 and figures 3 and 4 show that less than half of the 14 NHS trusts or central Government bodies achieved this level of performance. Mrs Lloyd, what issues have been affecting the payment performance of trusts, and are there any lessons to be learnt from the approach taken in this area by the local health boards?

[50] **Ms Lloyd:** Might I just correct an assumption first? It was just over half the trusts that actually met the target; it is not good enough, but they did meet their targets and they have now improved much more. I will come back to that.

[51] The scale of differential that we are dealing with has to be recognised. Trusts have to pass 1.14 million invoices, and LHBs have to pass 102,000, so there is a bit of a difference in scale. The LHBs have largely used the business services centre to undertake the payments of their invoices, and we have learnt from that that it would seem to be an effective and efficient way to do it. As a consequence, Christine has been leading a project in north Wales to look at a major shared services project across LHBs, trusts and their partners, to ensure that the good practice in the business services centre can be made more effective by trusts joining in.

[52] The trusts have worked hard on this and their performances have improved during this last year, with only three failing. Two failed at 94 per cent, so with just a bit of a push they would have been there, and only one, which is one of the north Wales trusts, was at 90 per cent. They are well aware that this is an important matter, particularly for local traders. There is legitimacy about failing to pass some invoices. If there really is a question mark about the way in which an invoice has been calculated, I think that it is appropriate to challenge it. It is a key issue and we are going to evaluate the north Wales shared service project, when it starts later this year, to see whether there would be validity in rolling it out throughout Wales. That would mean that the business services centre work could be rolled into it.

[53] **Mick Bates:** To follow that up, I take the point that you made about the figures, but in 2003-04 there was a slight improvement, if you look at that, but less than half—

[54] **Ms Lloyd:** In 2003-04, nine failed and five met the target; in 2004-05, eight met the target and six failed; and this time, 11 passed and three failed. So, they have made quite an improvement.

[55] **Mick Bates:** That is good to hear because the improvement agenda is what we are all about.

[56] **Ms Lloyd:** Yes, that is right.

[57] **Mick Bates:** Would it be possible to say a little more about the north Wales project? Although I take the point that Mrs Lloyd made about the difference in the volume of invoices that the trusts and health boards have to deal, one would look towards the robustness of that system, which would then be able to deal with any volume effectively. Is the weakness down to the internal system or the management?

[58] **Dr Daws:** We have already seen the fact that an NHS trust deals with 10 times the volume of invoices dealt with by an LHB, but it is also about the nature of those invoices. A large proportion of local health boards' invoices are paid to NHS trusts. LHBs are not buying consumables in the same way that NHS trusts are, and, obviously, they are across a lot of sites and, therefore, it is a fairly complex system. The improvement that we have seen is really quite significant in that sense.

2.00 p.m.

[59] Looking to shared services in north Wales, one thing that I want to do is standardise processes across the organisations. You are absolutely right that we would be looking for best practice, so we would try to standardise the best process across whichever kind of organisation it was, and pull that into one place, so that we can get the economies of scale as well as best practice. What we are doing at the moment is developing a balanced scorecard that identifies the key performance indicators now before the shared service is initiated, and then we will track and have a balanced scorecard and we will be looking for continuous improvement once the centre is up and running. That is quite important, because people will be saying, when the centre is up and running, 'Oh, this does not work as well', but we will have the key evidence. So, it is really important for us to benchmark before and afterwards.

[60] **Mick Bates:** Let us hope that we see a further improvement.

[61] **Jocelyn Davies:** I will just ask Mrs Lloyd a follow-up question on that, if I may. You mentioned that not all the invoices will be entirely accurate when they are received, or they may be invalid for some reason. What sort of proportion of the invoices received by trusts do you expect there to be a problem with rather than there being a problem with the payment of the invoice?

[62] **Ms Lloyd:** On the basis of the estimate made by the accountants and the people who have to deal with these payments, we have set the level at 95 per cent. We think that that is reasonable. We also track the amount of money, because it might be that you pay 95 per cent of your invoices but it is 20 per cent of your cash, so we have to ensure that not just the numbers but also the volume of resource are being paid expeditiously.

[63] **Jocelyn Davies:** So, the failure to meet 95 per cent is not because the invoices are invalid, because that is accounted for in the 5 per cent. Is that right?

[64] **Ms Lloyd:** We believe so, yes. I think that they just need to smarten up their processes a bit more.

[65] **Mick Bates:** My question is for Sir Jon this time. Figure 4 shows that the figures fell slightly below the level of required payment performance in 2004-05. Given the increased payment volumes that it has responsibility for following the merger of the sponsored bodies, what improvements are you proposing in this area?

[66] **Sir Jon Shortridge:** As I think I told the committee last year, I was very disappointed that we had got to 94.5 per cent in 2004-05. Last year, we got up to 97.2 per cent and I will be very keen to maintain that level. I have two particular risks that I am managing around that. One is that the two former sponsored bodies that were the worst performers have now merged with us, so I have inherited organisations that had a poor performance on pay, and I have to address that. Secondly, because I am rolling out a new payment system as part of our accrual accounting, there is a big training job to be done where people are having to switch from one system to the other. One can foresee that that could give rise to certain processing problems in terms of the timing of processing. So, I am having to manage those two risks, but I made it clear to Peter and everyone else involved that we will not drop below 95 per cent this year.

[67] **Mick Bates:** That is very encouraging.

[68] **Leighton Andrews:** Just for the record, you said that two bodies merging in are the two worst payers. Are we talking about the Welsh Development Agency and Education and

Learning Wales?

[69] **Sir Jon Shortridge:** You have got one out of two. [*Laughter.*] We are talking about ELWa and the Wales Tourist Board. I should say that, in the case of the Wales Tourist Board, it made a significant improvement in 2005-06 against its performance in 2004-05, but it needed to do that. Its performance was at 78 per cent in 2005-06.

[70] **Leighton Andrews:** We hope that it achieves the more commercial targets of the Welsh Assembly Government.

[71] **Janet Davies:** Thank you, Leighton. Mark, did you want to come in?

[72] **Mark Isherwood:** To clarify, figure 4 shows that, across the Welsh central Government sector, there was a decline in payment performance approaching 20 per cent after three years of improvement. Would that be your responsibility or, if not, whose responsibility would it be? Could you shed some light on how that has occurred and what remedies you have put in place to prevent it in future?

[73] **Sir Jon Shortridge:** I suppose that you could say that, ultimately, it is my responsibility, and I would not want to evade that. On the other hand, on a day-to-day basis, it is the responsibility of the accounting officers of the individual Assembly sponsored public bodies to secure the performance, because they are the chief executives, essentially. Over a number of years, I have addressed the ASPB chief executives on this. Over the last 12 months, I have written two letters to them, most recently following this report, expressing my concern about performance. It is a regular item that we discuss when we have our meetings of accounting officers. So, they are in no doubt as to my views on the fact that they must improve their performance.

[74] In terms of 2005-06, and the year after this report, 12 bodies were above the 95 per cent mark as against the eight bodies for 2004-05, but that is not quite as good as it sounds, because, in 2005-06, it was 12 out of 18 bodies, whereas, in 2004-05, it was eight out of 15 bodies. So, there has been a slight improvement, but not sufficiently significant yet.

[75] **Janet Davies:** Okay, thank you. Mrs Lloyd, I am sorry about this—I am feeling a bit thick at the moment—but I am not quite sure whether I understood your last answer. When you said that the payment performance is set at a level of 95 per cent, did you mean that the other 5 per cent is nominally considered to be the amount of bills that are challenged, and that the 95 per cent should be met, because they would not be challenged?

[76] **Ms Lloyd:** Yes.

[77] **Janet Davies:** Right, thank you. We will go on to risk management.

[78] **Jocelyn Davies:** The auditor general reports that the NHS has led the way in developing risk management arrangements. Could you outline what the key factors have been in this?

[79] **Ms Lloyd:** Risk management in the NHS is vital to patients and staff alike, and we have always therefore tried to propose and put into place robust governance arrangements, because of the impact of our governance not being good. We set up Welsh Risk Pool management standards many years ago, and they have been refined over time. At the moment, I am reviewing their suitability for transfer into a wider and broader-based risk management system, in an attempt to put in place really good integrated governance proposals, which will be built into improved health care standards and which will be reviewed by Healthcare Inspectorate Wales. We want to deeply embed financial and corporate governance into

clinical governance to bring them more closely together. However, we are not going to get rid of the Welsh Risk Pool management standards until I am absolutely assured that we have something at least more comprehensive, and which can be better assessed for the future.

[80] The way in which we developed risk management in Wales was to get measurable standards, some of which are core and which people must meet—and I can come back to those if you wish. They represent minimum standards that any good, well-performing organisation should meet. If they do not meet them, it would have an impact on the way in which they conduct their business. We have always had audit committees and standards, and we have been quite prescriptive about the arrangements that we expect to see. We have produced NHS finance and governance manuals, alongside best practice. An accounting officer's responsibilities are clearly set out, and we train our accountable officers. At the moment, I am auditing the way in which those officers conduct themselves, because I have many more of them than I used to have with local health boards. As you will know, David Richards, your principal finance officer, has been seconded to me for the next 18 months to conduct an independent review on my behalf, working with the auditor general, to see whether we can improve governance arrangements and training in the NHS.

2.10 p.m.

[81] Our core standards cover the main risks, and that is very much about asking organisations whether they have a risk management policy and strategy, and whether they do their risk assessments properly. Do they report adverse incidents, and what do they do about them? Do they report their hazards and, if there are main hazards coming through, are they disseminated properly? What are their governance arrangements, and how do they manage their money and the rest of their assets? All organisations have to meet those core standards to 75 per cent, and they are all independently assessed.

[82] We are trying to see whether self-assessment will give us as robust an assurance, because we are trying to reduce the burden, as you know. However, we have to make jolly sure that we maintain the standards that have been set and start to raise them further.

[83] **Jocelyn Davies:** You mentioned good practice, so I would like to ask both of you about the rolling out of good practice. On this committee, we have often found isolated examples of good practice, but there has then been a failure to roll it out. What mechanisms are in place to ensure that good practice is actually rolled out?

[84] **Ms Lloyd:** One of the advantages of the Welsh Risk Pool management standards is that they are owned and operated by the service itself, and there is nothing like the service taking a bit of ownership for it to roll out good practice. These are generally published standards, and the results are published, too, and our regional offices follow them up every year with organisations. There is a very full assessment of who has done something creative and innovative, and of who really is the epitome of good practice, and that is rolled out every year.

[85] The percentage against which we expect people and organisations to perform increases, and the standards get more prescriptive and more wide. We expect them now to meet not only their core standards, but also the vast majority of their other standards, of which there are about 45—it is quite onerous. We have also built in continuous improvement, so that they are very carefully monitored on this. The Welsh Risk Pool, operated by Conwy and Denbighshire NHS Trust, has taken a really positive lead in disseminating good practice throughout the NHS in Wales, with John Bowles, its manager with specific responsibility for this. Given that governance is so important to the service, and the failure of governance is usually such a disaster, I have found that chief executives with accountable-officer status are only too keen to ensure that their services can come up to the standards required.

[86] **Sir Jon Shortridge:** I have a less directive approach, I suppose, which reflects the different nature of my relationship with ASPB chief executives from Ann's relationship with the health service that she runs. My expectation is that the chief executives of the sponsored bodies make full use of all the guidance and best practice on risk management that is available. I certainly ensure that it is made available to them, and we have discussions at our regular meetings on these issues. I then look to the assurance that I get from the auditor general in the special assurance reports that I ask him to undertake in addition to his management letters. So, I intervene only if I have evidence before me that the individual sponsored bodies are not performing satisfactorily in this regard. In paragraph 3.15, the auditor general is saying that he is encouraged by the progress that is being made.

[87] **Jocelyn Davies:** Mrs Lloyd, would you say that one of the key factors there is actually having an officer that leads that, with special responsibility for rolling out good practice?

[88] **Ms Lloyd:** Yes, I think so. The other thing that we demand is that, if people fail the standards, they put forward their action plans to show how they will improve, and that is monitored carefully. It is a big credit to Conwy and Denbighshire trust that it has taken such a prominent lead in the improvement of patient safety generally throughout Wales in the last few years, as well as the encouragement lent by that particular chief executive to others to raise the profile of the real importance of risk management in the health service.

[89] **Jocelyn Davies:** I have another question for Sir Jon, if that is okay. Is the Assembly on course to implement its resource-based systems by March 2007?

[90] **Sir Jon Shortridge:** It certainly is at the moment, and that goes back to my earlier answer about introducing what we call 'e-grants' and 'e-procurement', which is our accrual accounting system. I want that in place across the whole organisation by the end of this calendar year. We are rolling it out department by department; we are currently on course with that, but it is not just a question of rolling out the system; it is a case of making sure that all the associated training goes along with it, so that people know how to operate that system. If we hit that deadline of the end of this calendar year, it means that in the last quarter of the financial year we will have had access to this accrual accounting information and, apart from the intrinsic value of it to me and my senior colleagues, it will assist with the closing of our 2006-07 accounts.

[91] **Jocelyn Davies:** In terms of the training issue that you have just mentioned, is that the main challenge that you face?

[92] **Sir Jon Shortridge:** I would not overstate it; I just have an expectation that Peter and the people rolling out the systems will ensure that the training is being done in an appropriate way. I think that one of the benefits of doing it on a rolling system is that you can take the lessons from how it went into one department and use that to improve the way in which you roll it out into the next one. So, it is a risk that we are managing, but I have an expectation that it is managed properly.

[93] **Jocelyn Davies:** Are there any other risks apart from training?

[94] **Sir Jon Shortridge:** I had better bring in Peter, but whenever you are developing and rolling out a new IT system, there are risks.

[95] **Mr Ryland:** This touches on the previous question to some extent. Training is the single biggest obstacle. I do not see any other very substantial risks involved in this. It is all about making sure that people understand what the process is for, what the changes are, and

that they apply the new process uniformly across the organisation. I do not see any other substantial risks.

[96] **Janet Davies:** Thank you, Jocelyn. Going on to the issue of procurement, Mark would like to come in.

[97] **Mark Isherwood:** I refer you to paragraphs 4.1 to 4.6 and figure 5, which detail the work of Value Wales over the last year. I would like to ask Mrs Lloyd whether the progress there has been mirrored in developments within the NHS. If it has, what has that progress been; if not, could you please explain why?

[98] **Ms Lloyd:** The NHS has a number of procurement initiatives and a well-defined procurement practice, because we have had to group our procurement between organisations for very many years, because we have always found that if you can purchase in bulk, and some of our purchases are very specific, it is better if you have one organisation dealing with that. So, we established the NHS Wales supplies consortium some considerable time ago. Again, they are owned by the service.

[99] We are working with Value Wales at present to see whether or not our procurement practices should be improved upon, and whether there are certain areas of our current procurement that would be better provided via Value Wales, but we are sharing practice at present, as it happens. We have modern procurement systems. We capture information on which to build up the portfolio of how best to procure for the future. We have many initiatives going on. All our organisations have specialist procurement advisers and because we spend a huge amount of money we have always had to place a heavy investment on making sure that we really do get value for money. It is quite a sophisticated system that is used in the health service but we are working with Value Wales to see whether or not there are even better ways to procure for us and how we can learn from one another.

[100] **Dr Daws:** To add to that, Welsh Health Supplies has been ahead of the game for a number of years. Even in 2003-04 it was declaring savings of over £5 million in its annual report, and in the previous five years to that, it had savings in excess of £20 million. So, the NHS has been doing this for a number of years and we now need to up our game with Value Wales and see what we can do across more public sector organisations under ‘Making the Connections’. However, do not think that the health service has been behind; the health service has been ahead. It is important that that is recorded.

2.20 p.m.

[101] **Mark Isherwood:** In reference to a Welsh purchasing card, do you participate in that scheme and, if not, could you?

[102] **Dr Daws:** The Welsh NHS has its own purchasing card system and the question now is: what benefits come from working across the different public sector organisations? There are already examples in Welsh Health Supplies working in north Wales, which we want to build on in the shared initiatives in north Wales, where there have been joint contracts between the health service and local government on specific things, because we are purchasing the same things in a number of areas. We have to build on that kind of work. There are also huge opportunities in north-west Wales, where there are already joint contracts with the University of Wales, Bangor. So, that is where the big savings will be made and that has to be the next push under ‘Making the Connections’, namely the public sector in Wales getting its act together as one public sector body.

[103] **Mark Isherwood:** Box 5 tells us that 96 per cent of public sector organisations in Wales have participated in Value Wales training programmes. It also tells us that 62 public

sector organisations have been involved in the Buy for Wales initiative. We know that 65 accounts in central Government and the NHS were audited by the Auditor General for Wales. On that basis, if 62 out of 65 participated, that almost matches the 96 per cent who have undertaken training. Is that a fair comparison, or am I missing something there?

[104] **Sir Jon Shortridge:** My arithmetic is not very good this afternoon. I think that we had better give you a note on that so that I do not give a spontaneous answer that could mislead you.

[105] **Mark Isherwood:** Can we have clarification on that?

[106] **Janet Davies:** Yes, of course, and Sir Jon has agreed to provide that.

[107] **Mark Isherwood:** Thank you. My next question is more specific to Sir Jon's area. Value Wales has focused on areas where quick procurement gains could be achieved with success, but what key improvements do you think are still needed to ensure continuing economies on a long-term sustainable basis?

[108] **Sir Jon Shortridge:** Is that question for me?

[109] **Mark Isherwood:** Yes.

[110] **Sir Jon Shortridge:** The main challenge is to improve the level of collaboration across the public sector. Most of the public sector has been brought into the concept of Value Wales, but we need to increasingly convert that buy-in into engagement with collaborative procurement exercises that are being put in place. At the moment, I would say that it is patchy. I have a statistic that demonstrates that, on average, 30 per cent of the public sector is engaged with collaborative procurements. That is not to say that only 30 per cent ever engage, but if you think of all the collaborations that are around, taking each in turn, it will probably result in a different 30 per cent, if you see what I mean. So, we need to build on the platform that we are establishing and I think that we are still in the position of capacity building here and I echo what Ann and Chris said. I think that the health service in Wales, is, for the most part, ahead of the game and we have to learn from it.

[111] **Dr Daws:** I was going to say that the next area that we are focusing on specifically in north Wales is taking the end-to-end process and looking at how you are purchasing better based on what the customer needs. So, by improving your processes and by sharing some of them in a central area, you can improve the end point for the customer. When you then start to purchase together, you get much better savings from that. So, some real process improvements can be made through the chain, as it were, as well as by all of us buying things together, which can result in big savings.

[112] **Mark Isherwood:** That has come just in time.

[113] **Dr Daws:** In part, yes, but it is also about quality and ensuring that, if many people buy different things in a trust, what we would begin to get is a catalogue, whereby you have an evidence base and source not the cheapest, but the most cost-effective product. Once you start to get all of the information on a catalogue together for one region, you can start to make better improvements in how you purchase. If you have a good catalogue, you can also be sensitive to local businesses. So, you get the best quality as well as the best value.

[114] **Janet Davies:** It is important to bear in mind the issue of local businesses.

[115] We move on now to part 5.

[116] **Mick Bates:** I turn to page 20 and part 5. In paragraph 3, we get an update on the closure of the 1994-99 European Union programmes. Only one programme now remains to be finalised. Paragraph 5.7 reports that some improvements are appearing in the way in which projects are being managed, but that concerns remain over the systems of internal control that are in place. Sir Jon, given that the closure process for the old programmes is now almost finalised, how are lessons from this process being taken forward?

[117] **Sir Jon Shortridge:** It is not just from this process. We now have substantial experience going back over a substantial number of years—some 12 or so—in terms of implementing structural funds in Wales. I see the issue as being one of a process of continuous learning and improvement from everything that happens in relation to the implementation of those schemes. Obviously, what we learn from the EU auditors when they come along is important, but we do not want to wait until right at the end of the process to take up that learning, so, we take important learning from the capacity that we now have for article 4 monitoring, which is at the earlier stages of the application for grants, and our article 10 monitoring.

[118] I was talking to Bob Macey, the chief executive of the Welsh European Funding Office, earlier today, and he is of the view that it is his and his senior management team's constant role to learn from everything that happens in respect of the structural funds payments process, so that he can continuously improve that service. I think that he is looking in particular to build that learning into the arrangements that we have put in place for the next round of structural funds, starting next year.

[119] **Mick Bates:** That was quite a general response, so what were the key lessons that you are moving forward?

[120] **Sir Jon Shortridge:** I will have to give you a note on that, because Bob and his team are the experts, but, if you look at figure 7 and the auditor general's comments, the number of audit observations has been reducing. The main lesson from the combination of those two things is that we need to focus on the internal controls—not my internal controls, but those of grant recipients. So, we are not just talking about recipients in the public sector, but in the voluntary sector and also in the private sector. It is about getting people who are not perhaps as used as we are to maintaining information systems and audit trails in respect of public money to do that to the satisfaction of our auditors and also of that of the European auditors. That, for me, is the main issue that comes from this report. To put it into context, these internal control issues are often not of a nature that puts the grant at jeopardy; it is simply about improving the compliance in the way that funds and overheads have been apportioned and things such as that.

[121] **Mick Bates:** Fine. Perhaps you are really referring to the training that is needed for the project sponsors and managers. Should compulsory training be a condition of the awarding of the grant, for example?

[122] **Sir Jon Shortridge:** I cannot give you a straight answer to that; I would have to be clear on whether we had the powers to make that a condition of grant payment, and, on the face of it, we probably do not. However, I will give you a short note on that. Training is a fundamentally important issue and it is the one that we are focused on.

2.30 p.m.

[123] Following my last Audit Committee appearance of this nature, I wrote to all accounting officers and chief executives of public bodies in receipt of structural funds, stressing the need to ensure compliance with EU regulations, and training is a part of that. Bob Macey, at his own level, as chief executive of the Welsh European Funding Office, wrote

a similar letter. We are holding training sessions and workshops and seeking to improve the capacity of the grant recipients to comply with quite difficult requirements. That process will continue.

[124] **Mick Bates:** So, presumably, when we look at the—[*Inaudible.*]—programme, we will see internal controls figure much reduced, hopefully?

[125] **Sir Jon Shortridge:** I would hope so, and I would just say that we should not overstate the importance of that; it is an important issue in itself, but, to a significant extent, it is not putting structural funds at risk.

[126] **Mick Bates:** Finally, what is the latest position of the closure of the final programme and on any potential financial loss to Wales?

[127] **Sir Jon Shortridge:** I am not able to comment on whether or not there may be potential financial loss to Wales. We are way off that, as far as I am concerned. There are discussions taking place, as I understand it, between WEFO and EU auditors on what are, to a significant extent, a range of technical auditing issues, which they have picked up on in relation to this particular programme. Until those discussions have been concluded, I will not be in a position to take a view on the significance of it.

[128] **Mick Bates:** May I clarify an issue in the report? In paragraph 5.2, a specific amount is deducted from the 18 programmes. As yet, there are no financial figures for the particular industrial south Wales programme that we are referring to.

[129] **Sir Jon Shortridge:** There are no financial figures and we are in discussion about that. We are aware of concerns that the EU auditors have and we are seeking to satisfy those concerns.

[130] **Mick Bates:** Fine. Is there a time limit to that consideration?

[131] **Sir Jon Shortridge:** I think that it is entirely a matter for the EU auditors as to when they want to bring this to a conclusion. It is not in my control.

[132] **Janet Davies:** I will take you back a little bit, Sir Jon, to this issue of various organisations' understanding of the financial and accounting rules to which they need to keep. Clearly, 1994-99 is quite some time ago. We are coming now towards the end of the present round and we will then be going into another round of structural funding. My experience is that there is such a different culture in some organisations from the culture that you get in Government when it comes to public money that it is very difficult to get them to really understand the issues. Are there any good practice guides in Government to try to explain to them how important it is to keep to the rules and get things done on time?

[133] **Sir Jon Shortridge:** There is a lot of guidance. WEFO produces comprehensive guidance covering all aspects of structural funding from application through to the claiming stage, and this is constantly reviewed and improved to address the problems that have arisen. There are specific guidance notes supplementing that on such things as overheads, in-kind match funding and so on. We are constantly building up the guidance, but I imagine, particularly if you are in a small organisation, that the sheer volume of the guidance itself becomes part of the problem. I do not think that one should underestimate or belittle the sorts of issues that we have to deal with here in trying, proportionately, to help the grant applicant to be able to engage with the system, not just to our satisfaction, but to the rigorous requirements of the EU auditors.

[134] **Janet Davies:** I thoroughly acknowledge that it is a very difficult issue to come to

terms with, so I will leave it there and go on to Catherine Thomas who has a question on the Freedom of Information Act 2000.

[135] **Catherine Thomas:** Moving on to page 23, paragraph 6.5 concludes that, in general, Assembly sponsored public bodies have made good progress in putting in place systems that meet the requirements of the Freedom of Information Act 2000. Sir Jon, what impact has the Act had within the Assembly? Are there systems in place that are sufficiently robust to meet demands in this area?

[136] **Sir Jon Shortridge:** On the impact, since the beginning of last year—I cannot quite remember when it came in—we have received 1,273 freedom of information requests, and we have completed 1,108 of those. We have received 36 complaints, which are mainly about the length of time that it takes to reply; 10 of these have been referred to the information commissioner, but, as yet, only three have been resolved, largely to our satisfaction. Therefore, that is the impact in terms of statistics.

[137] On the impact on staff time and staff business, these things can be incredibly time consuming, which is why we have not often been able to meet the 20-day deadline. However, having said that, I do not want to give the impression that I regard freedom of information requests as a nuisance—it is fundamentally important in a democratic society that people should have the right to access this information. I try to give as much personal support and leadership as I can to providing a proportionate and appropriate response to every request that comes in.

[138] Could you remind me of the second part of your question—I do not believe that I have dealt with that, have I?

[139] **Catherine Thomas:** Are the systems that are in place sufficiently robust? The Act came in on 1 January 2005.

[140] **Sir Jon Shortridge:** Our systems have been robust enough to create the statistics and the quality of service that those statistics indicate. We have invested heavily in training, and so on, and we have guidance in place. The one system that we need, and do not yet have—and will not have for some time—is an electronic document management system. If you have one of those, it is easy to identify all the relevant papers; without that, you have to employ people to go through, often, tens, or sometimes hundreds, of files, to pick out the relevant material. That is a big deficiency. However, putting in place an electronic records management system across an organisation as complex as the Assembly, and having everyone understand how to work it, is expensive and is a huge business systems development and change. It is in my to-do programme, but it will be some time before we have it in place.

[141] **Catherine Thomas:** If it is in your programme, what is your timescale for it? The efficient recording of requests is important so that you can monitor them. On the 20-day deadline, do you currently have the information to share that would tell us how many requests are not meeting that deadline?

[142] **Sir Jon Shortridge:** On deadlines, the answer is ‘yes’ and ‘no’. We know how many have not met the 20-day deadline, but, often, we will have secured an extension to the 20 days; I do not have information on the number where we have reached agreement to have an extension. Therefore, the bald statistic is that we complete 35 per cent within 20 working days. I cannot give you a statistic on the number, or the proportion, where we have not complied with the Act in terms of extensions.

[143] **Catherine Thomas:** If you have to go over the 20 days—and the majority of requests do—what is the maximum number of days that we are talking about?

[144] **Sir Jon Shortridge:** I do not have a figure here for the maximum, but I would not be surprised, with one or two complex and large requests, if we were talking about several months; for all I know, we might have a request that is up to one year old. However, if you want further information on that, I will have to give you a note.

2.40 p.m.

[145] **Ms Lloyd:** I can add to that, as someone who Sir Jon monitors heavily on this. The FOI requests that we tend to get in the health department are highly complicated. Often, we have received FOI requests that are so discursive that we almost did not know where to start. There have been a number of occasions when we have had extensions to the 20-day rule, for a variety of reasons—to clarify precisely what information is being requested or because the information requested relates to individuals and we have to seek permission from those individuals to release the information to a third party. I have to admit that two of my FOI requests are outstanding from the first day that the Act came into being, because I have to contact 3,000 people, some of whom might not live where they did when the information was requested. It is very complicated. The Permanent Secretary has a very efficient system whereby he will tell me every month, 'Oh dear, you have x outstanding; why is that?'. He holds us to account quite rigorously.

[146] We have had to set up a small team within my department to manage my FOI requests, because, on the whole, they relate to the treatment of individuals or to information that individuals have given to us or third parties. We have to be very careful, because patient confidentiality is written right the way through us and you breach that at your peril. Patient confidentiality is one of the things that we are just not allowed to breach, and that is quite right, too. So, the requests that we have to deal with are quite complicated and that is why I set up a small team to ensure that there was a standard approach to this matter, that we were not breaching confidentiality and that we maintained standards at all times. The Permanent Secretary monitors us very rigorously indeed.

[147] **Catherine Thomas:** As Assembly Members, we all understand the importance of confidentiality. I have another question for Mrs Lloyd—

[148] **Leighton Andrews:** Could I just come in? Do you have a figure for the proportion of freedom of information requests that have come from the Welsh media?

[149] **Sir Jon Shortridge:** I do not have it with me. If I can easily produce that figure, or an indicative figure, without having to breach the 20-working-day rule, I will make sure that the committee has it.

[150] **Leighton Andrews:** Okay.

[151] **Catherine Thomas:** Mrs Lloyd, you touched on part of the question that I wanted to ask. Are you confident that NHS bodies are equipped to meet the requirements of the Act and how are you monitoring them?

[152] **Ms Lloyd:** Until recently, we had a member of the team who specifically looked at producing guidance and help for the NHS. Unfortunately, that person has now gone and we have not yet been able to recruit to fill that post, but we shall. For a long time, the NHS has had to cope with the issues that arise from the Freedom of Information Act 2000. I think that many of the working practices that the Act requires were already embedded within the service because, often, in dealing with complaints, you were actually dealing with the same set of issues.

[153] I have asked the regional offices to ensure, as part of their check on how organisations are managing with the pressures and strains on them, that they are not feeling overburdened and to find out whether they have got their training right. It is becoming hugely onerous, but no-one has complained to us that that is the case at the moment; it has not been reported to me anyway. I have also asked the regional offices to ensure that the organisations are confident, or gaining in confidence, that they are managing this Act effectively and are not being reported to the information commissioner. I have not been informed that that has been the case so far. We have had one complaint against us, but that was overturned by him; it was comforting that he said that we had already provided far more information than he thought was usual.

[154] **Jocelyn Davies:** Has the Freedom of Information Act 2000 affected what information is now being retained?

[155] **Ms Lloyd:** From a patient point of view, the openness of the availability of patients' records to the patients themselves caused a major change in the health service, seven or eight years ago, in the way in which information about patients and individuals was recorded. I think that that was where the major change came in the health service because, prior to that, there was a certain looseness, on occasion, in the way in which details about individuals were recorded. That was tightened up much more then.

[156] In terms of whether people will commit themselves and their advice to paper, I do not think that that is the case. I certainly have not noticed a change in the way in which my officials provide me with advice, or in the way in which I advise the Minister, because of the Freedom of Information Act 2000.

[157] **Sir Jon Shortridge:** I would go along with that. You could say that, increasingly over time, the Freedom of Information Act 2000 will drive up standards, in that it has put a stop, or is progressively putting a stop, to frivolous e-mails, inappropriate language and so on, and it is very good that that is happening. One of the things that Ann and I have to be rigorous about is that decisions are properly recorded and that the advice continues to be without fear and favour. I have seen no evidence to suggest that there has been a diminution in that respect.

[158] **Jocelyn Davies:** I just said that I wondered how it had affected it; I was not suggesting that you looked at information and said, 'Oh, I am going to bin this just in case somebody wants to look at it later'.

[159] **Sir Jon Shortridge:** It is a legitimate concern that has been around that it will affect standards of administration in governance, and I have a duty to ensure that it does not.

[160] **Janet Davies:** What do you think are your financial management priorities over the next year?

[161] **Sir Jon Shortridge:** I think that my main priority is to manage the governance of risks associated with the mergers. As I said at the outset, having 1,600 additional staff with lots of new responsibilities, turning the organisation into much more of a delivery organisation, is a huge change, and I am determined that it should be a change for the better and a successful change. However, no-one should doubt the fact that there are significant risks involved when you have a change of that scale, literally taking place overnight. This committee spent quite a lot of time talking about ELWa, as I recall. I am managing a situation that is, on one level, much riskier than that. So, that is my top priority, I suppose.

[162] My second one is to ensure that the new Assembly and the new Assembly Government, if I can use those terms, are successfully established in May 2007, subject to

Parliament, and there are all sorts of financial and governance issues associated with that.

[163] Thirdly, I am determined, as you heard earlier, to implement this accrual accounting system on time. Associated with that, I am also determined to secure the faster closing of accounts, and we have a particular complication with our accounts next year because it will be the first time that the Assembly's accounts incorporate the sponsored bodies that have been merged in. So, it will be less straightforward, and, anyway, there is the faster closing.

[164] I suppose that my bottom-line requirement is that the auditor general should continue to be able to state that the standards of financial management and probity within this part of the Welsh public sector remain high.

[165] **Ms Lloyd:** One of my key risks is the potential for financial failure within the NHS, where it is unable to manage its finances within the limits of resource and starts to make decisions that have not been properly risk-assessed and which have consequences for staff or patients, or both. That is a major concern of mine.

[166] A second concern is that it does not come forward effectively with reconfiguration proposals that will allow it to move the agenda on in terms of the effective provision of value-for-money health and social services for the future. It would therefore be running itself into a problem in 2009 when the European working time directive comes into effect, and it might find that it is unable to safely run its services. So, that is a major driver for me.

2.50 p.m.

[167] A third risk would be that, in terms of the cost of the staff contracts for 'Agenda for Change', trusts do not use their benefits realisations effectively, and run with staffing structures that are no longer fit for purpose. As we know already, in 'Agenda for Change', there is a huge gap around the healthcare assistant grade, namely grade 4, which needs to be filled. They must look at reconfiguring their services well, and they need to do something in terms of the more experienced nursing or allied health professional grades. If they just sit on their staffing structures, they will not realise the benefits and they will be in trouble. If they do not use the Compass system that we have developed on consultant workloads, and if they do not use the quality assessment framework scores for general medical services properly, they will not realise the benefits of these massive improvements in staffing resources that we have provided to them. If they do not manage their waiting times, they will be penalised, and that will add to the financial pressures that they have.

[168] I could go on, but there are a number of various pressures on the service, and one of my big concerns is that the organisations out there must collaborate better to ensure that they spread the competence and the capacity better than they have in the past. They have worked in silos, and they have started to recognise that they must join together more effectively for the future, in order to realise the effectiveness of the resources that have been given to them, and to plan better across their borders to deliver care more appropriately.

[169] **Janet Davies:** Thank you. Seeing as you both have significant financial management challenges, our successor Audit Committee may have very interesting meetings next year. I thank Dr Dawes, Ms Lloyd, Sir Jon and Peter Ryland for their helpful answers. You will be sent a draft transcript of this meeting's deliberations before its publication. We will take a 15-minute coffee break now, and I think that we will see you back here afterwards, Ms Lloyd. I ask everyone to come back by 3.05 p.m..

Gohiriwyd y cyfarfod rhwng 2.53 p.m. a 3.09 p.m.
The meeting adjourned between 2.53 p.m. and 3.09 p.m.

Amseroedd Aros y GIG: Adroddiad Dilynol
NHS Waiting Times: Follow-up Report

[170] **Janet Davies:** I welcome you back to the second part of the meeting. First, I need to ask Mrs Lloyd and Mr Hill-Tout to introduce themselves for the Record.

[171] **Ms Lloyd:** I am Ann Lloyd; I am the head of the Health and Social Services Department and the chief executive of the NHS in Wales.

[172] **Mr Hill-Tout:** I am John Hill-Tout; I am the director of performance and operations in the Health and Social Services Department, and I have the policy lead on waiting times.

[173] **Janet Davies:** Thank you. We will now look at the follow-up report on national health service waiting times. Just over a year ago, the committee held three evidence-taking sessions on NHS waiting times in Wales. In May 2005, we published a highly critical report and concluded that waiting times for Welsh patients were too long. We made 13 separate recommendations, aimed at encouraging the Assembly Government and local healthcare organisations to take a longer term, more strategic approach to tackling NHS waiting times and their causes.

3.10 p.m.

[174] Today's update report, provided by the auditor general, enables us to examine the progress made by the Welsh Assembly Government in response to those recommendations. We will all be pleased to note the positive progress that is being made in reducing long waits and addressing the underlying causes in a clear and strategic context. I hope that we can focus positively on how this progress can be sustained to deliver the challenging new 26-week waiting target by December 2009.

[175] Mrs Lloyd, if we look first at paragraph 1.1 and figures 1 and 2, in your opinion, what have been the main reasons for the welcome reductions in long waiting times for patients?

[176] **Ms Lloyd:** Primarily, the focus on the importance of achieving these targets, both in relation to the benefits to the health of the population and ensuring that we have a more appropriate response to managing people who are waiting for intervention and elective care. The Cabinet decided to invest on a three-year basis—because it only has three-year financial cycles, as you know—to improve the waiting times in Wales and, as part of that, to look at the role that waiting times and the management of elective care played in the whole of the system of healthcare in Wales. So, the £80 million that we receive per year has allowed us to have significant discussions with the NHS over a three-year period to ascertain exactly how it will make the improvements that are so necessary.

[177] We did not just leave it to chance, either. The performance management system has been improved as well. We put into place a delivery and support unit, which has two functions. The first is to go into those organisations where help is needed—if they need to have their lists reassessed or their processes reassessed, a suite of experts from the unit will go in to do that, or it will undertake analyses of precisely what is wrong with the system in any organisation for the Minister and our department, and will stay with that organisation, giving it a weekly analysis of its performance until it starts to improve. There is a lot of training, education, commitment and involvement engaged there. So, we set that up. The unit currently manages what we call the Access 2009 project, so, it is taking a main role in that. It also operates a suite of intervention protocols. If the Minister decides that the performance of an individual organisation is insufficient, he will send the unit in and it will not come out until he is happy for it to come out.

[178] We have also ensured that there is much tighter management by trusts of their waiting lists and times. They have been validated and externally reviewed to ensure that their validation has been correct. We have a number of targets around that validation, namely, how many people are on the suspended list and why they are there. We do not expect more than 5 per cent of any list to be suspended at any one time. They have been asked to produce local delivery plans for precisely how they are going to manage to move towards these targets on a month-by-month basis. If there are breaches, then the chief executive must submit an individual report per patient on why the person breached. That has cleared out a lot of sub-optimal practice and administrative failures in the system, which was counting people who were not breaching as breaching. So, the whole system has been tightened up and that has been good.

[179] We have also had to examine the other factors affecting waiting times, namely, the fact that elective care is limited because of emergency access and what we are going to do about that, diversion schemes and demand-management schemes and all those sorts of things. There has been a whole raft of performance indicators that have been imposed on the service and the service has risen fantastically well to the challenge of reducing waiting times in Wales.

[180] **Janet Davies:** So, in that case, do you feel that these published figures are robust? I should say to you at this point that someone came to me in May this year who was told that she had to wait over 18 months to get a scan and another 18 months to have in-patient treatment for a very severe condition. After I took the case up with the trust and the Minister, she is now having the scan next month and an operation in September. I was concerned about whether this was a one-off or whether it was a sign of a deeper, underlying problem.

[181] **Ms Lloyd:** I am glad that there has been a resolution to that individual's problems. John and I get one-off cases where inappropriate information has been given to patients, but we are constantly vigilant about our information. Diagnostics is different, and I will come back to that if I may. We have a number of patients who are saying that they are being told that they will have to wait far longer than our waiting times and yet they are not being reported in. We follow up each and every one of those concerns. On the wider question of the validation of these lists, we have taken action on those, but we are looking to have an independent source of scrutiny of the lists to make sure that we are quite clear that these are as clean as is possible.

[182] **Mr Hill-Tout:** Just to add to that, there are also issues around the way in which lists are currently managed. If a patient reports to you that he or she has been on the list longer than the maximum wait time, when we have examined those situations, often it is because the patient at some time has been suspended. So, the patients themselves may have been suspended because they have cancelled an appointment or have been unable to attend an operation, or their clinician has suspended them for medical reasons, and therefore, for them, the clock has stopped. However, they have an understanding that they have been on the waiting list for that long. As part of the 2009 strategy, our strategy is to remove this focus on suspensions and get those out of the system, because I think they are a source of confusion. They are necessary at the moment, because you have to stop the clock if the patient is not capable, for example, or well enough to have the procedure, but they can cause confusion in the minds of some patients.

[183] **Ms Lloyd:** However, no-one should be told that they have to wait longer than the access target.

[184] **Janet Davies:** And this, of course, was after a six-month wait for a first appointment. Thank you very much for that. Christine Gwyther is going to continue.

[185] **Christine Gwyther:** Speaking from my experience of casework, people are still being told that they will have to wait more than 18 months. This is not an isolated case and we have to be very vigilant in our own areas and, obviously, you do as well. I refer you to figures 1 and 2, which show the rate at which waiting times have been coming down, and they look very encouraging. I am pleased to see that the line is much further down now than it was a few years ago. However, the line does not go in a straight trajectory; it is wiggly, which shows that trusts are using one-off measures at various times—I guess at the end of the financial year—to try to meet their targets. How confident are you that the recent lower figures will not rise again as trusts do not use these one-off measures to reduce the waiting times?

3.20 p.m.

[186] **Ms Lloyd:** We have asked for local delivery plans from all organisations, and they have been scrutinised rigorously. All but one has been signed off, and we believe that we will probably sign the last one off very shortly; there has been a bit of a dispute about that one. We are also very mindful of the bounce that occurs every year in April and May, and so we were particularly relieved—because there is three-year funding, and because we have been dealing with three-year analyses of how they meet these targets—when we had the May figures, to see that this bounce had not occurred. There had been a slight rise in out-patients waiting over 12 months, but most of those were for Cardiff and Vale NHS Trust dermatology services, where there is a dispute going on, which we are trying to resolve, between the trust and its local health boards about its long-term delivery plan. We hope to be able to resolve that quickly. That accounted for the vast majority of the increase.

[187] Month by month, the delivery and support unit has been rigorously looking at what the projections for each organisation would be, how many patients the organisations would be able to see, and what the demand was like; we now collect GP referral figures and we are able to feed back to GPs on the quality of their referral, to ensure that we do not have bounces. We put in sustainable solutions to the management of waiting times, and the management of elective capacity.

[188] **Christine Gwyther:** Figures 3 and 4 deal with regional variation. If I were a north Wales AM, I might be slightly more relaxed about this, because waiting times are far lower in the north than they are in south and mid Wales. How soon will it be before what could be seen as this postcode lottery is eliminated?

[189] **Ms Lloyd:** It will be eliminated by the time that we get to 2009, because everyone has to get down to the best. The variations that you can see over those two years are reducing; we would expect to see a further reduction, because one of the main drivers for Government is the equality of access and treatment, and opportunities. The variances can be put down to the effectiveness of the provider and the effectiveness of the commissioning. We have urged the organisations to address these regional variations. You can see from figure 3, in particular, the benefit of the action that has been taken by organisations to redress the balance. Therefore, they will be eliminated—we hope that they will be eliminated before we get to 2009. We will keep our eye on the commissioning projects from each of the LHBs, or the regional consortia, to eliminate this variance that exists now.

[190] **Christine Gwyther:** In figure 4, I am pleased to see that most of the waiting times for in-patient day-case treatments have reduced significantly. However, in Swansea, it has risen alarmingly. Could you give us the reason for that?

[191] **Mr Hill-Tout:** This figure shows the number of people waiting more than six months. Therefore, in effect, what you see there is that, as the trust has focused on its long

waiters, it is condensing its waiting lists, so that the numbers of people are being reduced, but it is focused on the tail end of the list. You therefore see an increase in the lower parts of the list, as we are encouraging them to treat patients from the back of the list; that is what has occurred there. However, Swansea NHS Trust is achieving all of its targets. Therefore, although it is an issue, the trust is achieving its targets now, and we will continue to monitor that.

[192] **Christine Gwyther:** But why is Swansea so markedly different? All trusts must surely be concentrating on the back end of their waiting lists first. Why is there such a huge difference in Swansea?

[193] **Mr Hill-Tout:** In the initial part of the period, Swansea was less adept, shall we say, at that concentration. You will see from the report that it had started that exercise of pulling people from the back of the list much later on; in fact, we financially penalised it as a consequence. Therefore, what we see there is that the trust has made significant improvements, but it still has more to do in how it manages its list. As Mrs Lloyd described, the delivery and support unit is working with that trust, and has been for the last 12 months, and will continue to do so, so that this sort of anomaly is eradicated.

[194] **Jocelyn Davies:** On Swansea, I believe that we have been told before that it does all the plastic surgery for the whole of Wales.

[195] **Mr Hill-Tout:** Almost all.

[196] **Jocelyn Davies:** Well, the surgery for all of south Wales, then. A very few people have been waiting a very long time. Does that impact on these figures?

[197] **Mr Hill-Tout:** It could do. It is certainly a specialist centre. It treats all the plastic surgery cases for south and mid Wales. People from the north flow into England for their plastic surgery. It could be that, and it does have other specialist services, such as neurosurgery, which might have an impact on this. If you would like me to, I could do a further examination of that and give you a written response.

[198] **Jocelyn Davies:** If they are carrying out specialist services and there are very long waits for that and those patients obviously come from all over Wales—I think that they do obesity surgery there as well, do they not?

[199] **Ms Lloyd:** Yes, they do.

[200] **Jocelyn Davies:** Do you think that you could give us a note on that?

[201] **Mr Hill-Tout:** I can give you a note on Swansea.

[202] **Jocelyn Davies:** We may find that there are some patients who have been waiting a very long time for specialist surgery at Swansea.

[203] **Ms Lloyd:** That is why Swansea was put under special measures. It had the deliver and support unit with it the whole of last year to make sure that it started to manage its lists appropriately.

[204] **Christine Gwyther:** Finally, Chair, is there a difference in management between north Wales and the rest of Wales, whereby north Wales might be using more day surgery? It might be better at dealing with delayed transfers of care and its bed capacity might be better.

[205] **Ms Lloyd:** It is quite difficult to give a very definitive answer to that, because the

performance of all these organisations is different. You will know that, in the service and financial framework target set by the Minister last year, the Minister included a number of efficiency measures, including average lengths of stay, delayed transfers, cancelled operations and day-case rates, and all organisations in Wales were given a target that they had to meet. Some of them met that target and some did not, and some of the targets were very specific. I get a report at the end of each month, showing precisely where individual organisations are in terms of their effectiveness in meeting these targets.

[206] On the whole, the north Wales organisations seem to manage appropriately, but that does not mean that you take your eye off them, because they can have swings during the year. The main pressures that we have found are all along the south Wales coast, including Swansea, Cardiff and Gwent. They have the biggest demands made of them and they have to move the furthest in changing their practice. We are working constructively with them on how they might do that. The establishment of the two elective centres in Gwent and Cardiff will help enormously, in that they will have elective capacity that is really ring-fenced and that no-one will be able to get into, unless they are elective. Also of enormous help will be some of the changes in practice that they have promoted over the last year.

[207] Some, however, were finding that with the best will in the world, their accommodation was such that their ability to provide day-case surgery was really hampered. So, we have been investing in that as part of the local delivery plans. We have been asking them for their capital programmes to aid them in meeting some of these targets. I think that we have had about 65 schemes in, which we are pursuing, as part of the local delivery plans, to enable them to meet the day-case targets better. Some of them, through no fault of their own, just could not do it because they did not have the set up. However, the performance is variable and is published on a quarterly basis and we would be happy to circulate that to you.

[208] **Christine Gwyther:** I can accept that some hospitals might not be designed in such a way that makes day surgery easy. However, I submitted a written question to the Minister last week on day surgery at Withybush Hospital in Pembrokeshire and the figures for 2004-05 were better than the figures for 2005-06. Therefore, clearly, it has retrenched in its efforts to increase day surgery. Can you explain how that sort of thing can happen?

3.30 p.m.

[209] **Ms Lloyd:** Withybush is one of the hospitals that has a real problem in trying to provide good quality day-case facilities, although it depends which day case you are looking at. It has failed on its arthroscopies and it has managed its bunions fine and its cataracts and it is not too bad on the hysteroscopies. So, in some areas, it has done okay and exactly what is right but, in other areas, it has failed, and we are pursuing that with it. It might be that the equipment is insufficient and that is what the delivery and support unit will follow through with it when we get these results.

[210] **Janet Davies:** We will turn to address the causes of long waits.

[211] **Mark Isherwood:** I refer to paragraphs 1.3 to 1.15 and the underlying causes. Why do you think that the rate of reductions in cancelled operations effectively stalled and actually slightly increased over the year in question, that is, 2005-06?

[212] **Ms Lloyd:** Over the last three years, the rate of cancelled operations has generally increased in that last quarter. What we have found is that that denotes the pressure on the whole system. You tend to get more emergency admissions and, therefore, you cannot get so many patients through. It is also a symptom of planning throughout the whole year, which is why we have tried to encourage hospitals to plan more effectively and not to expect all the patients to come in in January.

[213] However, if you look at what has happened subsequently, it did go up in March, to 3,614 cancellations, but it dropped in April to 2,523 cancelled operations, which is the best that we have had for the last five years. We shall be tracking this very carefully to see that this downward trend continues. We are also looking at why operations have been cancelled and it is still quite a concern to me that so many of these operations—two fifths, approximately—are cancelled by the patient. Is it because we have not given the patient long enough to think about what is going to happen to them? Is it because we have not consulted them effectively enough on when the operation may or may not take place? That is work that the delivery and support unit is doing for us. If you look at the non-clinical reasons for hospitals cancelling, you will see that, again, those are still too high. That is another two fifths, and some of that is about the processes that organisations use. I find it unacceptable for operations to be cancelled because the consultant is on leave, when consultants have to give six weeks' notice. That should be completely avoidable.

[214] Hospital cancellations for clinical reasons are valid, obviously. You must have good pre-assessment and it is at that stage that you might find that an operation is cancelled, but we have to do far more work on the reasons why patients cancel and the non-clinical issues, because we simply have to drive the number of cancelled operations down. It is such a waste of resource and it causes such frustration, both for the staff and, more importantly, for the patient.

[215] **Mr Hill-Tout:** Just to add to that, if I may, the issue really is about reducing the differences in efficiency between trusts. What is not acceptable is if one trust is returning, because of efficiency reasons, a poorer cancellation rate than a neighbour. That is why, if you look on page 11, where the auditor general has recounted the efficiency targets, the Minister has indicated, in this year's targets set for the NHS, five key efficiency targets that everybody has to hit. So the intention of that is to get, if you like, everybody improving so that we do not have so much variation in efficiency, which is counterproductive.

[216] **Mark Isherwood:** Following on from a previous point, we see a mixed pattern, where some seem to be getting worse and some seem to be getting better, and that is consolidating on a middle position, which is, possibly, well below the best being achieved previously. Are you confident that the April figure will be reproduced, or is it too early to say that it will continue to improve? If not, what further actions can be taken to reduce cancellations?

[217] **Ms Lloyd:** It is too early to say at the moment whether we will maintain this trend, because it dips every April or May, but it has not dipped quite as much as this before. We have put out a good practice guide for elective admissions and elective surgery, and I have also asked the national leadership and innovations organisation to undertake a modernisation assessment of each organisation, to ensure that modernisation techniques are embedded within those organisations. They are now getting back their individual scores on how well they have done, and both the National Leadership and Innovation Agency for Healthcare and the delivery and support unit are producing a script for each organisation on the areas in which they must improve and the way in which they might improve. They will continue to work with them during this year to ensure that we drive down cancelled operations, which are now part of the service and financial framework, and on which the Minister is asking for particular evidence to show an improvement. He is sending the delivery and support unit into areas where he does not feel that sufficient progress is being made, and to ensure that we keep a very tight grip on the use of the facilities so that we provide an efficient service, in which people's operations are not cancelled all the time or they do not have a bed.

[218] **Mark Isherwood:** You also talk about rates and the proportion, but do we know if the absolute demand is changing?

[219] **Ms Lloyd:** We do indeed. We are producing the GP referral rates, which are being fed back to each practice. LHBs are being charged with looking critically at their referral rates to see whether or not they are equivalent to what you would expect from their population. There are some strange returns at the moment, and we are checking some of the information to ensure that we are not asking them to do something on the basis of faulty information. It is a major part of the commissioning process to ensure that the referrals are appropriate, and you will know of the work that has been undertaken in some of the LHBs on a pilot basis to set up referral centres, through which all referrals from their area will go and be managed. The quality of the referral will be fed back to the individual GP practice to try to ensure that people are not being put into the system, and having to wait for a specialist opinion, when they might have been redirected to somewhere more appropriate at an earlier stage. Associated with the referral systems, we have initiated and paid for some of the LHBs to put in diversion schemes so that GP specialists might see patients instead, and they are being evaluated. So, a lot of work is being done on managing demand more effectively.

[220] **Mark Isherwood:** Right, thank you. The report tells us that measures that have been introduced to address pressures on emergency admissions, but, nonetheless, we are told that the ratio of emergency to elective admissions has remained the same for the last four years. Why do you think that is and when do you expect that the measures that have been taken will impact on the throughput of elective patients?

[221] **Ms Lloyd:** The Minister is about to produce his delivering emergency care services strategy, which looks at the trends that have occurred over the past years and the changes in the way in which people can access emergency care. It tries to streamline the way in which people will access care. At the moment, they can go through a number of areas—they can go to NHS Direct, the out-of-hours service or straight to their accident and emergency department, and we know that there are large numbers of patients who are completely confused about how to access care when they need it. Most of them will go to the emergency unit. That might be appropriate but it might not, and they may have to wait much longer than necessary and they might have been treated faster had they chosen a different route. So, we are trying in this new system to bring all these sources together so that there is one informed access point, so that people are directed much more effectively to the place where they will get the appropriate treatment in a speedy way.

3.40 p.m.

[222] We are also looking at the ambulance service becoming far more of a clinically driven service, rather than a transport system, so that paramedics are able, more effectively, to provide front-line services. That seems to be welcomed by the unions and the staff at the moment; they are very pleased by some of the reports that have come from England, particularly those developed by a guy called Bradley in London, who is also helping us, and by Roger Thayne himself. This will be a real opportunity to take a step forward in terms of how people access care, to ensure that people are directed appropriately with the right information to the right place. That will be quite an innovation when it comes in, and it has been well-signed-up-to by clinicians and—

[223] **Mr Hill-Tout:** And by the professional organisations.

[224] **Ms Lloyd:** They are very pleased with it.

[225] **Jocelyn Davies:** On the point about patient cancellations, it is a large number, as you mentioned, Mrs Lloyd. You gave several scenarios for why a patient might cancel his or her operation, but how do you know that the patient has not already purchased that operation in the private sector, which could be another option?

[226] **Ms Lloyd:** We do not.

[227] **Mr Hill-Tout:** It could be one of the reasons.

[228] **Ms Lloyd:** It could be one of the reasons, but we do not know. There is an issue with asking them that.

[229] **Jocelyn Davies:** Yes. I think that you have mentioned patient cancellations to us before, so when do you think that you might be in a position to discover why? This is quite a serious problem, so what actions are you taking to discover why it happens, so that this does not keep occurring year after year?

[230] **Ms Lloyd:** The DSU is, at the moment, analysing the reasons why patients have not attended, and the current reasons are that the appointment may be inconvenient, they are unfit for surgery, the operation is not wanted, or they just have not turned up. We can do, on a restricted basis, a first sift on these reasons. If it is a matter of the operation not being wanted, we have to have a further investigation, with the patient's permission, into why he or she did not want it, to ask some relevant questions, without being too intrusive. The DSU is looking at that work for us now.

[231] **Mr Hill-Tout:** The key to this—I know that, in paragraph 1.11, it says it, and it also says it in the NLIAH guide—is pre-operative assessment. In Wales, not every trust offers pre-operative assessment; they all need to. If they offered for every patient to be seen by a nurse or a junior doctor an appropriate period before their surgery, all of these questions would be dealt with. As well as the clinical issue, the social issues, if you like, such as 'I have had my surgery elsewhere', would be communicated. If we can attack that, and improve pre-operative assessment and make it uniform across Wales, those cancelled operations will fall dramatically in number. That is certainly our view, and I think that it is the view of the auditor general; that is where we need to focus our efforts.

[232] **Jocelyn Davies:** I have dealt with cases in which patients do not want operations, but their families do want the patients to have operations.

[233] **Mark Isherwood:** Appendix A refers to Llandough Hospital. When do you expect it to be operational?

[234] **Ms Lloyd:** I am sorry, I missed that.

[235] **Mark Isherwood:** Appendix A refers to Llandough Hospital. When do you expect that hospital to be fully operational?

[236] **Mr Hill-Tout:** This is CAVOC, the Cardiff and Vale orthopaedic centre unit?

[237] **Ms Lloyd:** Yes.

[238] **Mr Hill-Tout:** The background to the CAVOC unit is that it is being constructed in two phases. Phase 1 of CAVOC was the creation of a new bed-template, operating theatres and some out-patient facilities. In phase 1, the out-patient service is already open and functioning, and that was through a capital scheme funded by the Assembly and a revenue contribution of £2.5 million, which the Welsh Assembly Government made to the community to get the first phase of CAVOC up and running. Out-patients began being seen in that department some eight weeks ago.

[239] Phase 2, which is the in-patient and other aspects of the unit, is not yet open, and that

is because, effectively, it is part of the local delivery plan for the Cardiff and Vale community. That community has had the largest share of the £80 million that was made available, but it also has the largest number of patients to be treated. So, the complexity is in agreeing the level of work that can be dealt with through Cardiff and Vale and through CAVOC. It is the last local delivery plan to be finalised. All the others have been signed off, but Cardiff and the Vale's local delivery plan has not been signed off. That work is currently in progress; in fact, we had a meeting yesterday with the community. We are optimistic that, once that local delivery plan has been signed off to our satisfaction, the CAVOC unit will go ahead and will be opened. At present, stage two is not yet functioning.

[240] **Mark Isherwood:** I will move on now to paragraphs 1.16 to 1.27, which describe the introduction of a clearer central strategy within which to improve waiting times. How confident are you that you have generated sufficient improvements in performance management to ensure the rapid delivery, hopefully, of the strategy in health communities?

[241] **Ms Lloyd:** In having to deliver such a challenging target we had to risk assess what we felt would be the major challenges for us. One of those challenges was being able to performance manage this effectively and make sure that there was enough support for the service to take the steps that were necessary. So, the establishment of the delivery and support unity with automatic intervention, if organisations were failing to meet their profiles, came in. The introduction of breach reports does concentrate the mind; if you have to write a report on every patient who breaches, it is an onerous responsibility. There is much site-specific work also taking place supported by NLIAH's modernisation team and the DSU. We are looking at the scores that are applied to how well people manage their waiting lists and we have the guide to good practice. We monitor these on a month by month basis. If the Minister decides that he is not satisfied with the progress being made, he can increase the intervention. He believes that it is really important that we do not fall behind in this. So, there are a number of risks identified in the work streams for the 2009 project, many of which are outlined in this report and with which we would agree. Action has been taken on each of those to ensure that the performance management wrapped around those is as tight as it can get. We are also working very constructively with the English team that is driving the 2008 target to make sure that we share good practice.

[242] **Mark Isherwood:** I think that performance management has to become cultural. How are you managing the change? How are you ensuring that people actually identify where they can take ownership for it?

[243] **Ms Lloyd:** I think that it was interesting; we were at the Health and Social Services Committee yesterday at which there was some evidence being given on cancer. The consultant at the meeting said, 'We have all seen your letter about the delivery of the cancer wait standards; it is taken seriously'. If we can get that sort of reaction from the clinicians who have to deliver at the end of the day, it is obvious that the trust managers are making sure that their clinical teams are on board with doing this important piece of work. Without them, and without their expert knowledge about how patients might be best served, the delivery plans will not be delivered effectively.

[244] The trust chief executives know that if they fail to deliver these targets, which are must-do targets—we have to do this. It is being backed by the Cabinet, they have provided extra money to do it and there is a lot of discussion about how it might be done—their organisations will be financially penalised. We did financially penalise two organisations last year for not doing what they set out to do and there was no good reason for that. The whole issue of the delivery of these targets has been raised right up the profile of the trusts and their clinical teams. They are monitored on a monthly basis; in fact, if the delivery and support unit is in there, they can be monitoring them on a daily basis, as was the case in Swansea towards the end of last year. It does concentrate the mind when you know that someone is going to ask

you, at the end of each day, 'Did you deliver what you set out to do today, and if not, why was that?'. The profile is up.

3.50 p.m.

[245] **Mark Isherwood:** You are probably aware that, at the BMA conference in Northern Ireland a few days ago, concerns around this sort of area were raised, which suggests that there is a two-way communication issue. How can you take that on board with your English colleagues to ensure that all the horses in the harness are pointing in the same direction?

[246] **Ms Lloyd:** Clinical engagement is absolutely crucial. In Wales, we have some really excellent clinicians who have very bright and innovative ideas about how better to manage patients. We have to harness their enthusiasm and their ideas. We have had a number of seminars throughout Wales where clinicians have been only too pleased to present the different ways in which patients might be managed for the future. We have to make sure that the good practice is properly spread throughout Wales, which is why we had the modernisation audit undertaken, much of which relates to better clinical interventions and has been informed by the individuals within Wales about best practice and managing clinical management of patients. The full engagement of clinicians in management and accountability for the delivery of services, in the round, not just this, has not been as well advanced in Wales as it probably is in England. I think that they started in England a long time before we did. Nevertheless, it has improved enormously. When I go around, I meet large numbers of very enthusiastic clinicians who want their ideas to make a real difference to patients, but we have to make sure that that is universalised throughout Wales.

[247] **Janet Davies:** Mark, we will have to leave this bit now, because time is getting on and we need to move on to Mick Bates's questions. I am sorry about that.

[248] **Mick Bates:** You used the term 'concentrate the mind'; there is nothing like money to concentrate the mind. In figure 9, we see your new tools for better planning actions and strategies to reduce waiting times for patients. This toolkit was used to calculate the figure of £80 million per year. How confident are you that your calculations are accurate and that £80 million per year is enough to deliver the 2009 target?

[249] **Ms Lloyd:** We have done some very detailed modelling about the management of this target. I think that you can see that we more than triangulated the techniques that we were using. We were extremely cautious about this before the Cabinet was advised of the resource, which is why we did not just rely on one individual organisation saying, 'You will need x to do y'. We tried to ensure that all the bases were covered. Arising from all this work that you see in figure 9, the figure was arrived at. In terms of its success, we will not know whether it is successful until we get to the end of it, but it is being tracked very carefully. However, despite some grumbles here and there, the local delivery plans—apart from one, which is imminent—have been signed off and people are, to date, delivering this. The amount of resources regarded on our risk register has to be there and we have to keep a very close eye on it.

[250] **Mr Hill-Tout:** Just to supplement that, Chair, I think that the funding is there. It needs to be linked with the efficiency, which is why the efficiency targets are there, because we have already discussed varied efficiency, and it needs to be linked with the modernisation. With the three things together, we are confident that we will deliver in 2009.

[251] **Mick Bates:** How confident are you that cross-border information is collectable?

[252] **Ms Lloyd:** This is a problem. I am in close contact with my colleague, Ian Carruthers, on this issue, and I have spoken to him at least three times in the past month about

it and other matters. In England, they only count GP referrals in, whereas we count everyone; no matter where the referral comes from, we count it, and that is why we found that, at the end of last year, there were 15 breaches, and they were all patients waiting for English hospitals to treat them. So, I have raised this with him again. We always knew that we counted differently, because we counted everything and everyone. His response at the moment is that, this year, he will be moving from the situation that they have at the moment—you have individual treatments, and that is your out-patient waits, and then you are into your diagnostic waits, and then you are into in-patient waits, if necessary—to having a proper patient pathway. So, he will change his collection methodology to having a whole pathway, so, it does not matter where the referrals come from as they will all be counted. That is important.

[253] The other thing is that I expect local health boards that are transferring patients to English hospitals to keep track of those patients. I have been talking to the border local health boards about how they might better manage those commissioning decisions, because they should be clear that they are their patients and that they should be keeping track of them. We should not be finding that patients are waiting for a very long time for an opinion in England, when they would have received an earlier opinion if they had been in Wales.

[254] **Mick Bates:** I am sure that these cross-border issues will rumble on for a long time. As you are well aware, there are many funding issues that make commissioning difficult across the border. My final point looks to the future. Will trusts be sufficiently focused on delivering the long-term strategic changes needed to deliver these targets at a time when they are under intense short-term financial pressures?

[255] **Ms Lloyd:** I think so, and we are ensuring that, in looking at their local delivery plans, their reconfiguration plans and the financial pressures that they are experiencing, short-termism is not wiping out the long-term game. We are having some pointed conversations with many organisations about this, but they must modernise their services, and most local delivery plans did not get a good score in terms of modernisation. They must look at the best use of their resources, and they should not be taking short-term cuts that defeat their long-terms objective. That is one of the things that we have to do as a department to ensure that those things are balanced, and we must have a really constructive discussion with them about the pressures that they are under.

[256] **Mick Bates:** Finally, on the auditor general's first recommendation, which describes how the focus on the 29-week target could increase the risk of inappropriate activity, or even the manipulation of data, how do you propose to take forward the auditor general's first recommendation to develop systems to ensure that the data on waiting times are accurate and that local organisations are not manipulating the figures?

[257] **Ms Lloyd:** We are commissioning a baseline verification, in accordance with his recommendations.

[258] **Mick Bates:** I am sorry; you are saying that you are going to do that.

[259] **Ms Lloyd:** Yes.

[260] **Mick Bates:** When is that work likely to be undertaken?

[261] **Mr Hill-Tout:** This will be part of the 2009 programme—it has to be. We need the baseline verification, which will be done through the 2009 project team, and then we need to decide how best to monitor that on a regular basis. We will talk to our audit colleagues about that, and whether this is spot checking or something else. In England, as I understand it, a regular survey of all trusts is held on an annual basis. We may decide that, in Wales, we do

not need that level of checking, but that we need some level of checking, and we might want to go down the route of spot checking. Those decisions must be made, but the 2009 programme will commission the baseline verification of the start position, so that we can be clear that we have that and we know the position, and then we can check it.

[262] **Jocelyn Davies:** Mrs Lloyd, you mentioned the patient pathway earlier, and this report certainly points out that redesigning the patient pathway will need significant innovation to deliver the 2009 target. However, the local delivery plans have had a low score for innovation. So, will local health communities be able to deliver those changes? Will they rise to the challenge?

4.00 p.m.

[263] **Ms Lloyd:** You will have noticed that, in the report, mention is made of early adopters. We asked for two or three organisations that had come forward to become early adopters of a very different way of delivering care in a particular range of specialities, but specifically orthopaedics, which is a major problem for us, as it is for England. So, we have been lucky in that several organisations have come forward, which we have funded as part of the 2009 project, to take on board the modernisation of three specialities, and they are all different, except for orthopaedics. However, once others heard about it, they decided to join that programme. Even though they are not funded, four more trusts have joined the programme, including Gwent, which has had problems in the past with managing its waiting lists.

[264] We are sharing the experience drawn from those organisations with the service, underpinned by the modernisation audit that the National Leadership and Innovation Agency for Healthcare has undertaken, to ensure that this innovative practice is shared throughout Wales—it has been specifically funded for that purpose.

[265] **Jocelyn Davies:** The other questions that I wanted to ask have been answered already.

[266] **Janet Davies:** Thank you, Jocelyn.

[267] **Denise Idris Jones:** Paragraph 2.7 says that diagnostics and therapies have previously represented a bottleneck for patients, and that, until 2006-07, there have been no specific targets for diagnostics and therapies. How much of a risk is posed by waiting times for diagnostics and therapies, and what action is being taken to address the long waiting times in these areas?

[268] **Ms Lloyd:** This is indeed a major problem. Wales is the first of the countries to at least publish the data that it has. Of course, that, again, is subject to major validation, and it is part of the project. However, we are subject to some extremely long diagnostic and therapy service waits in Wales.

[269] We have looked at where the particular problems are, and how we might address those, again, through this project, as well as at how much investment will be needed to ensure that it becomes firmly embedded as part of the patient pathway in this 2009 project. To my mind, however, the diagnostic and therapy waits, at the moment, are the biggest problem that we have. The out-patients are largely being controlled as in-patients, but the diagnostic ones, as in England, are the main problem. Therefore, we have asked for particular plans from organisations to overcome some of the big bottlenecks that you see. It is not universally spread throughout Wales either; some areas do not seem to be under anything like the same pressure as others, but there are major concerns in my mind about doing this. The delivery and support unit is looking at this very critically and liaising with the English team to share

good practice on what it is doing. We are thinking about whether we have to go for a second-offer scheme for diagnostics as well.

[270] We have asked organisations to put forward their proposals for an increase or an improvement in their diagnostic therapy equipment, and those are coming through to us now, but we have to make sure that we have sufficient staff to use the equipment. In speech and language therapy, we really do have a major problem, as we do in physiotherapy, for which we have increased the numbers in training, but it nevertheless remains a major problem for us, and it is one of our greatest risks. A huge amount of effort is being applied to this.

[271] **Mr Hill-Tout:** Just to add to that, Chair, if I may, the early adopters are taking the view—and this may well be where we end up—that diagnostic waits will be in parallel with out-patient waits, so, once a patient has seen a GP, at the point that the GP decides to refer to a consultant, there will be a protocol in the pathway that says, 'With this condition, this patient needs to have this diagnostic procedure'. So, that must take place in parallel during the time that the patient is being referred to the consultant, otherwise you get staged waits, which we have now. So, that is why the pathway has to be redesigned, and that will be the final pathway; it will look like diagnostics are coming in parallel, or even before, so that, when the consultant sees the patient, all the test results are available to him or her.

[272] **Jocelyn Davies:** That makes sense.

[273] **Denise Idris Jones:** It does make sense, yes.

[274] The backlog of patients waiting for in-patient and day-case treatment has been addressed by purchasing extra activity in the NHS at weekends, or in the private sector. Is this a feasible option to increase the availability capacity for diagnostic and therapy services?

[275] **Ms Lloyd:** We regard the in-patient and out-patient schemes as short term. Part of the 2009 project is to build in sustainable capacity, to ensure that demands can be managed sustainably. It could be done on a short-term basis, using those methods, but we are trying to get a sustainable solution to some of these problems. Therefore, to overcome short-term requirements, we will be looking with organisations at whether or not that is appropriate. However, basically, we need a long-term solution to this.

[276] **Denise Idris Jones:** Therefore, in a way, we are not training enough speech therapists—is that the problem?

[277] **Ms Lloyd:** There has been a big dip in the past in training them, as well as in retaining them. We have increased the number of therapists in training considerably over the last three to four years, so we just have to ensure that they are employed effectively. Many of the trainees who are now coming out—and there are issues about it, which we are exploring with the service—need almost another year of training and supervision to be able to be self-standing therapists. We are working with the service on how that might best be achieved, because it is an added pressure for the existing qualified staff.

[278] **Denise Idris Jones:** In my area, there is an extra problem. I was speaking to an elderly gentleman on Sunday who had had a stroke, and whose first language was Welsh. He was going for speech therapy, but there was no point in doing this if the speech therapist could not speak with him in Welsh.

[279] **Ms Lloyd:** Exactly.

[280] **Denise Idris Jones:** Paragraph 1.20 notes that the Welsh Assembly Government's regional offices are currently producing plans for the reconfiguration of secondary care,

which should help support shorter waiting times. The reconfiguration of secondary care services is likely to lead to changes being implemented across NHS Wales. Might this adversely affect the delivery of the 2009 target?

[281] **Ms Lloyd:** No, it must not be allowed to. In looking at the proposals that are coming forward—and they are coming forward from the service, and not so much from us—we are looking at capacity and sustainability within those proposals. We are also looking at what the detailed modelling looks like in terms of the suite of options that are coming forward, to ensure that, if reconfiguration takes place, we are improving the efficiency and access to individual populations. We are also working with LHBs to look at what the community base service is for the future, what that looks like, and how we can improve telehealth and telemedicine so that there is greater access. That is being used successfully in north Wales at present—in fact, I do not believe that we could provide some services without it. It is to improve the spread of the take-up of those techniques. Therefore, 'Designed for Life' and its consequences cannot be seen outside the achieving of good waiting times in Wales—they are all part of the same thing, just as emergency admissions and detox are; it is a system that is in need of redesigning.

[282] **Catherine Thomas:** To pick up on the important point that Denise made about speech therapists providing support through the medium of Welsh, this is also a particular problem in Carmarthenshire. What are you doing specifically to address that shortage of speech therapists working through the medium of Welsh?

[283] **Ms Lloyd:** The trusts produce their workforce plans. As you know, the workforce development unit has now been established in NLIAH to take forward workforce redesign and the commissioning of education and training for our staff. Carmarthenshire has acknowledged that it has a problem with the shortage of Welsh-speaking speech therapists, and that is being built into the proposals. We are trying to get more creative placements so that staff will be encouraged to stay in those areas where they are most needed. If they have a particular expertise, we need to provide good quality placements for them, so that they will be encouraged to stay in those areas where there is a scarcity. We are tracking the take-up of employment, as we have done for the past year, of people who have scarce skills that are needed.

4.10 p.m.

[284] **Leighton Andrews:** On paragraphs 2.10 and 2.11, looking at the effects of long waiting times, I note that there is a cap on demand. One of the dangers is that if waiting times reduce substantially, suppressed demand might suddenly flow out. What is your assessment of that in respect of the 26-week target?

[285] **Ms Lloyd:** We have been tracking demand carefully because, at one time, it looked to us as though the number of patients requiring out-patient treatment was going up steeply. The trends, however, at the moment, are showing a flattening out of demand. We were concerned that the shorter the waiting times became, the greater the demand would be. We are finding that the total waiting lists trends are flattening for out-patients and, in fact, they are going down for in-patients. We will be keeping a close eye on that because it has been an important factor in designing the 2009 and beyond project. We also have referral schemes in place to ensure that referrals are appropriate and are going to the appropriate place, and they are providing a loop of information back to organisations and primary care. We are mindful that this could be a danger, but, so far—and particularly since about March 2003—the trend in out-patients has flattened away from the quite steep curve that it was on.

[286] **Leighton Andrews:** May I ask about the issue raised in paragraph 2.11, about the threat of a pandemic? Is it part of the planning of your 2009 access unit to look at

contingencies around this?

[287] **Ms Lloyd:** Yes, it is indeed. Of course, if there is a pandemic, our first priority has to be to manage those people who are critically ill. We are about to discuss with the general practitioner community what its response would be. We have trends from the Chief Medical Officer's department on what pandemics might look like, and he is modelling three or four types for us at the moment, so that the deliver-and-support unit can model the consequences. Of course, we do not know when it will happen, but he is sure that it is going to. I think that a judgment would have to be taken on whether or not we would suspend the target in the advent of a serious pandemic in Wales. I think that that would have to be a judgment made by the Government, but we would have to deal with that, first and foremost.

[288] **Leighton Andrews:** Would that judgment have to be made at a UK level at the same time?

[289] **Ms Lloyd:** Yes, I would think so. We might not come to the same decision, but it would have to be at the same time. [*Laughter.*]

[290] **Leighton Andrews:** I will not go there.

[291] **Christine Gwyther:** You touched earlier on the fact that the engagement of clinicians is important in driving down waiting times. There is a clear political and moral imperative to drive down waiting times. However, forgive me for being cynical, but is it not useful for clinicians who also operate in private practice to have waiting lists that are as long as possible, because then they will pick up more private work? How are you engaging with clinicians in a direct enough manner to help them to overcome that real dilemma for them?

[292] **Ms Lloyd:** We have long been aware of the consequences of long waiting times on private practice, and I am afraid that that is where I have to leave that one. However, we do have to engage the clinical community. As you know, we are the only country that is monitoring, in an open way, the consequences of the consultant contract—what the consultants are doing, what is reasonable for them to do, and their workload—and we are building those job plans and their consequences into the project. It is perfectly justifiable for clinicians to undertake as much work as they wish for the NHS or the private sector, but we have to ensure that those working with the NHS are being adjudged fairly between the specialties and that we can use their skills and talents to effect an improvement in these waiting times.

[293] However short waiting lists are, patients have a choice: they can always go to the private sector or not. We are also working with the private sector in getting a better handle on what is happening, what it can do for us and how its capacity can help us to achieve this goal. I do not know whether you want to add anything, John.

[294] **Mr Hill-Tout:** I think that, in terms of private practice generally in Wales, the numbers are very small. There is not a large amount of private practice in Wales anyway, so the extent to which consultants work outside the NHS hospitals—and, of course, they are entitled to do that—is fairly limited. By engaging with the private sector in this short-term period—for example, the second-offer scheme relied quite heavily on the private sector to ensure that NHS-funded care could be delivered in other settings—that is only a short-term expedient, but the private sector has been helpful in that regard, and I think that it will continue to be. However, measures like engaging with clinicians in the management exercise of tackling waiting times and the pooling of lists—so that if there are three orthopaedic surgeons offering care in a local hospital, the referral is always made to the consultant with the lowest list—will mean that we can keep the balance between the patient making the choice and having the NHS offer available to them, rather than their having to go to the

private sector. It has always been there, has it not? It is a dilemma that the NHS has faced since its inception. We need to manage that effectively, and I think that we do, on the whole.

[295] **Christine Gwyther:** I think that I would prefer it not to be there, personally, and that is a dilemma that we should not have to be facing. What is the ultimate sanction if the management of a trust believes that one of its clinicians is not moving things along as quickly as he or she should be? We are desperate for clinicians. How often are sanctions used against clinicians?

[296] **Ms Lloyd:** Consultants' contracts have only been in for a very short period of time, and it is only this year that the management members of trusts are obtaining the data on the sort of workload being carried by individual clinicians. They are members of trusts' staff and they have to deal with them as they would any member of their staff. They have to have that dialogue with them. They are supposed to review their job plans very regularly, and they must ensure that they are getting a fair deal. It is a problem if that is not the case. In my experience, trying to stop clinicians working too hard was my problem. The vast majority give far more than a day's work, quite frankly.

[297] **Janet Davies:** At the end of this evidence session, I thank you both, Mrs Lloyd and Mr Hill-Tout, for your very helpful answers. You will receive a draft transcript before it is published.

4.19 p.m.

Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio ar Ariannu Gardd Fotaneg Genedlaethol Cymru
The Welsh Assembly Government Response to the Audit Committee Report on Funding the National Botanic Garden of Wales

[298] **Janet Davies:** Jeremy, is there anything that you wish to say on this?

[299] **Mr Colman:** I have nothing to add to my letter. The response is satisfactory and it ranges far more widely than the particular case of the botanic garden, because the committee's report was also more wide ranging. We will monitor the performance, but, for now, it seems to be a good reply.

[300] **Janet Davies:** Does anyone else want to come in on this? I see not.

4.20 p.m.

Adroddiad Diweddaru ar Gaffael yn y Sector Addysg Uwch yng Nghymru
Update Report on Procurement in the Higher Education Sector in Wales

[301] **Janet Davies:** Again, Jeremy?

[302] **Mr Colman:** Again, this is a satisfactory response. I should draw attention to the fact that, as I mentioned in my letter, the sector is at an early stage in its efforts to improve procurement. Fine words have been said, and we must surely welcome them, but we will have to see what happens in practice. We will be keeping our eye on that.

[303] **Janet Davies:** Does any Member want to come in? I see not.

4.21 p.m.

Adroddiad Blynyddol 2005-06 y Pwyllgor Archwilio i'r Cyfarfod Llawn
Audit Committee's Annual Report to Plenary 2005-06

[304] **Janet Davies:** Are you happy with this annual report? Does anyone wish to change anything? I see not.

4.21 p.m.

Cofnodion y Cyfarfod Blaenorol
Minutes of the Previous Meeting

[305] **Janet Davies:** Are we agreed on the minutes of the last meeting? I see that we are.

Cadarnhawyd cofnodion y cyfarfod blaenorol.
The minutes of the previous meeting were ratified.

4.21 p.m.

Cynnig Trefniadol
Procedural Motion

[306] **Janet Davies:** I need to propose that we will end the public part of the meeting.

[307] **Leighton Andrews:** I am withdrawing from this part of the meeting, Chair.

[308] **Christine Gwyther:** It is probably best if I withdraw as well.

[309] **Janet Davies:** We note that Leighton and Christine have withdrawn from the private part of the meeting. I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 8.24(vi).

[310] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 4.21 p.m.
The public part of the meeting ended at 4.21 p.m.