Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 11 Rhagfyr 2008
Thursday, 11 December 2008

Cynnwys
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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 Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Eleanor Burnham	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Chris Franks	Plaid Cymru The Party of Wales
Irene James	Llafur Labour
Huw Lewis	Llafur Labour
Dai Lloyd	Plaid Cymru (yn dirprwyo ar ran Bethan Jenkins) The Party of Wales (substitute for Bethan Jenkins)
David Melding	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Ian Gibson	Dirprwy Bennaeth, Uned Llywodraethu Corfforaethol, Llywodraeth Cynulliad Cymru Deputy Head, Corporate Governance Unit, Welsh Assembly Government
Dr Andrew Goodall	Prif Weithredwr, Byrddau Iechyd Lleol Pen-y-bont ar Ogwr a Chastell-Nedd Port Talbot Chief Executive, Bridgend and Neath Port Talbot Local Health Boards
Helen Howson	Uwch-gynghorydd Strategaeth Iechyd, Llywodraeth Cynulliad Cymru Senior Health Strategy Advisor, Welsh Assembly Government
Ann Lloyd	Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head, Department of Health and Social Services, Welsh Assembly Government
Carol Moseley	Arbenigydd Perfformiad, Swyddfa Archwilio Cymru Performance Specialist, Wales Audit Office
Gabrielle Smith	Swyddfa Archwilio Cymru Wales Audit Office

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

Karl Gomila	Dirprwy Glerc Deputy Clerk
John Grimes	Clerc Clerk

Dechreuodd y cyfarfod am 1.30 p.m.
The meeting began at 1.30 p.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **David Melding:** Good morning, and welcome to this meeting of the Audit Committee. I will start with the usual housekeeping announcements. These proceedings can be conducted in Welsh or English. When Welsh is spoken, translation is available on channel 1 via the headsets. If you are hard of hearing, you can amplify proceedings using channel 0. Please switch off all electronic equipment completely, rather than leaving it on pause or standby, as it interferes with the recording equipment. We do not anticipate a fire drill this afternoon, so if you should hear the fire alarm, please follow the instructions of the ushers to leave the building safely.

[2] We have apologies from Bethan Jenkins, Janice Gregory, Lesley Griffiths, and Darren Miller. Dai Lloyd is substituting for Bethan Jenkins, and I welcome him to the meeting.

Rheoli Cyflyrau Cronig gan GIG Cymru
The Management of Chronic Conditions by NHS Wales

[3] **David Melding:** We move on to the substantive item on our agenda—the findings of the Auditor General for Wales's report, 'The Management of Chronic Conditions by NHS Wales'. This is an important and timely report about the provision of healthcare services for the 800,000 people in Wales who live with a chronic condition such as diabetes, emphysema or heart disease. People with chronic conditions place a lot of demands on healthcare services, and are often admitted to hospitals as emergency medical admissions, which might not be necessary if other, more appropriate services were in place. While the Welsh Assembly Government has started to address the issue of moving services from acute hospitals closer to people's homes, there is some way to go before we have a suitable range of services in the community, which will reduce demand on acute hospital beds.

[4] I welcome the witnesses to the meeting ask them to introduce themselves formally for the record.

[5] **Ms Lloyd:** I am Ann Lloyd, the head of the Health and Social Services Department at the Welsh Assembly Government and the chief executive of the national health service in Wales.

[6] **Dr Goodall:** I am Andrew Goodall, and I am the chief executive of Bridgend and Neath Port Talbot local health boards.

[7] **Ms Howson:** I am Helen Howson, and I am head of community health strategy in the Department of Health and Social Services at the Assembly Government.

[8] **David Melding:** Good afternoon and welcome to you all. I place on record my thanks to you, Ann Lloyd. Over the years that you have been in post, you must have been the most regular attendee at this committee.

[9] **Ms Lloyd:** I should say so. It seems like it.

[10] **David Melding:** You have always endeavoured to help us with our inquiries, and we are grateful for that. We wish you a fruitful and long retirement, which itself has been delayed by your desire to ensure that public service gets its full value for money from you.

[11] **Ms Lloyd:** Thank you.

[12] **David Melding:** We are particularly grateful that you are available to be the principal witness this afternoon. I know that you have made special arrangements to be here.

[13] To the other two witnesses, who may not have been to committee before, I should explain that we have a series of questions that we wish to put to you. We will work around the room, and you may attract my attention if you have something to say. Some questions may be put directly to you. I am sure that you will find that it works fairly naturally as we go through our list of questions.

[14] I will start with a very general question to you, Ann, and your colleagues may contribute if they wish. It is about the general findings of the report, and your reaction to it. As you know, we will then drill down into the specific detail, so we need not be long at this stage.

[15] **Ms Lloyd:** Many of the problems raised in the report from the Auditor General for Wales have been recognised by the Welsh Assembly Government, and the proposed solutions to these issues will be driven through our chronic disease management strategy and its associated service improvement plan.

[16] The information provided by the auditor general is extremely helpful in the important work that we are currently undertaking to ensure that each of the local health board areas has benchmarked its service against our proposed plan. This will help to inform our own understanding of the situation.

[17] A considerable amount of research, evidence-gathering, planning and development has been going on throughout the service since the data within this report were collected. Those data, together with this report, will be extraordinarily useful in informing our future actions. With your permission, Chair, we would like to leave with you a full update on where the service in Wales has got to over the past couple of years in trying to address this extremely important question of the future management of people with chronic diseases in Wales.

[18] **David Melding:** Thank you. I will be happy to receive anything that you wish to leave with us, although the principal evidence gathering will be done this afternoon.

[19] **Lorraine Barrett:** This is probably our third farewell, Ann. We are going to miss you.

[20] Looking at part 1 of the report, the figures show that there are around 200,000 emergency medical admissions each year and that one in six are of people with have chronic conditions. Figures 6 and 7 and paragraphs 1.13 to 1.17 show that there is a large variation in those emergency medical admission rates for chronic conditions between the local health boards, which is not easily explained by age or deprivation. Do you have any views or evidence as to why some trusts have been able to reduce emergency medical admissions for people with those chronic conditions and others have not?

[21] **Ms Lloyd:** There are a number of reasons, which vary throughout the country. There is a difference in prevalence and also in socioeconomic problems and there is a great difference in service provision and the way in which professionals within the service access care on behalf of their patients and clients. There are also fragmented services, and it is obvious from later on in this report that people do not have a clear picture of how they might access care and all of the options that are open to them, and whether or not they would be suitable. There are variations in responses, and one thing that Helen and I have been discussing in particular is to what extent people are confused in trying to access services

because things are called different names but are actually the same service, and about who is eligible for those services and so on. I think that there is a problem about that. There are big variations in the availability of community services. There are differences in the primary care structures and the way in which the general practice community can access its full range of services and who is undertaking which enhanced services, and so on. There is definitely inadequate information and communication, and we must be clear about that, and there are differences in the referral system.

[22] So, from our analysis of what is underpinning this problem, those are the sorts of issues that vary from community to community. With our framework work that is being introduced in this third quarter of this year, as part of the annual operating framework target, we should be able to more completely analyse the range and quality of services, information and communication with individuals. The take-up of that, particularly of the enhanced service elements for pharmacists and general practitioners, the mapping out of exactly what services are available, and the clarification of how patients, their carers and professionals might access those services to avoid admission should help the situation.

[23] **Lorraine Barrett:** Can Dr Goodall say something about the LHBs and what is being done for them to better understand and act upon the factors that are precipitating hospital admission for patients with chronic conditions?

[24] **Dr Goodall:** There is clearly variation in Wales, so, as individual organisations, we will look to our different localities. We work closely with the trusts and other agencies, and perhaps that is one of the changes that I would remark on since the last report. There is a challenge about partnership working and making this happen within the report, and chronic conditions management is not just an NHS issue. To reflect on local experiences, in Neath Port Talbot and Bridgend, we have tried to ensure that the debate is as much about promoting independence, and addressing the frailty of people, if you like, in social services language, as it is about chronic conditions.

[25] We have tried to look at which services are working most effectively. The analysis that we have here shows that there is fragmentation of services across the patch. Perhaps we have had a lack of understanding about what is most effective, but I think that the national model that has emerged gives us a good direction to follow, for example aspects such as case management and how that works in individual GP practices and how you work on that kind of approach. These are not just things that we are doing in Wales; there is a national evidence base to introduce that. It is important to look at the other support services for people in the community, and rather than just set up silos of chronic conditions management, if I can describe it in that way, we are also looking to ensure that we focus on the avoidance of hospital admissions.

1.40 p.m.

[26] So, again, from a local perspective, we have developed reablement services along with social services colleagues. We have looked at emergency response services to make sure that we avoid a hospital admission other than when it is fully appropriate. Those are not just local examples; such things have been progressing over the past two or three years with local health boards in Wales.

[27] **David Lloyd:** I want to flesh out the last point. The experience generally is that sometimes, medical admissions happen because the caring services are not available on the ground in the community. So, I want to give you an opportunity to flesh that out a bit more. As you said, this is not just about the health service, but also about caring agencies, social services, social workers, and their availability outside nine-to-five hours, at nights, weekends, bank holidays, Christmas—given that it is looming. So, what specific initiatives are you

engaged in as a local health board? A lot more work needs to be done to encourage partner organisations to view health and social care as an activity that is required 24 hours a day, seven days a week.

[28] **Dr Goodall:** I just want to take you back to the local approach that we have been taking around the Abertawe Bro Morgannwg trust area, particularly around Neath Port Talbot and Bridgend. Two years or so ago, we knew that we had a problem without needing to look again at our community services. Rather than do what I would describe as a 'traditional' review of district nursing services, we decided that this would be looked at differently: we would look at the opportunities to develop services together. It was not just about the local authority engagement and working with colleagues there; it was also about having an arrangement with the third sector and using voluntary organisations, too.

[29] For me, one of the missing parts of the jigsaw is recognising the level of support that is available within communities and through voluntary organisations. I certainly agree with the communication issues that Ann has raised. Many health professionals are probably unaware of the full range of voluntary organisations that are around in some areas to support people if they have specific chronic conditions. As an example, we have facilitated a directory of services, which is not in the traditional model of telling patients what is in the hospital; it outlines the full range of the community services that are available in the patch. We are looking at signposting initiatives where we can make sure that people are directed there and are working with GP practices. We have taken it further and, should people ring NHS Direct, that same local information is available through that national organisation.

[30] However, none of that takes away from the fact that we recognise that services need to be out in the community and need to be made available 24 hours a day, seven days a week. It is right that many of the existing schemes were set up to run from Monday to Friday. Our local debates in Bridgend and Neath Port Talbot are about how we can expand these services to ensure that they are available for the whole week. As the report says, most emergency admissions occur outside the normal hours.

[31] **David Melding:** Before I call Eleanor to ask the next set of questions, I inform Members that this is her last meeting with us, as she is about to go and do other work for her group. We will miss you very much, Eleanor. You have been a most diligent and well prepared member, and we are very grateful for your efforts over the past years. I hope that that is not too gushing an introduction.

[32] **Eleanor Burnham:** No, you are very kind.

[33] **David Lloyd:** Chair, you have cast a cloud over the proceedings. [*Laughter.*]

[34] **Eleanor Burnham:** I am very sorry that I am leaving.

[35] My official questions are on figure 8 and figure 9 in the auditor general's report. Some of the more formal questions are about the reductions in occupied bed days for emergency medical admissions for chronic conditions, but I am intrigued by figure 8. Perhaps you would like to explain to the uninitiated, Mrs Lloyd, the disparity between, for example, the very high figure of 150 per cent in Ceredigion and Mid Wales NHS Trust, and North East Wales NHS Trust, which is in my region, where the figure drops to minus 30 per cent. Before we move on to the official questions, could you explain that to me, because I am not a statistician or a mathematician, but it seems to be glaringly obvious that there is an intriguing background to that?

[36] **Ms Lloyd:** Thank you. The data in respect of Ceredigion show that there seems to be quite a reduction in the chronic conditions admissions, and then a massive increase in other

symptoms and signs. It is an outlier, but there seems to have been quite a swing, if I am interpreting the data correctly. We are investigating these sorts of swings. What are we saying? Are we saying that we have suddenly changed the definition of other symptoms and signs? That is one thing that we are looking at, and the National Leadership and Innovation Agency for Healthcare is, at the moment, undertaking a piece of work for us to look at the coding that goes on in hospitals. Previously, coding had to be done swiftly, because it was there to drive the money system and that sort of environment; now, it is there to inform practice and service delivery. So, have we suddenly changed the way in which the coding is being undertaken? That is being investigated at the moment, so I cannot give you a definitive view. Is it that people are being admitted for initial assessment, which may be a patient's first admission for a chronic condition but the condition is not yet classified as such? It is an extraordinary swing.

[37] **Eleanor Burnham:** That is why asked about this, because I found it intriguing.

[38] **Ms Lloyd:** It could be to do with rurality. That is the other—

[39] **Eleanor Burnham:** I wondered about that.

[40] **Ms Lloyd:** That is the other element, but you would then expect it to appear in Gwynedd.

[41] **Eleanor Burnham:** Thank you. That is kind of you, and thank you, Chairman, for indulging me. Mrs Lloyd, can the Government identify and quantify the resources that could be released through these small reductions in bed days to support community services? This is the same question as that which Dr Dai Lloyd has just asked, really.

[42] **Ms Lloyd:** The Welsh Assembly Government is aware of the drop in the length of stay and in the numbers of admissions, but, unfortunately, the rest of the admissions have risen as a consequence. That is why we are looking particularly at the classifications. Is this a problem that we think we are doing better at, but which might be hidden? That is being looked at. We put in additional resources to enable change to take place, through Wanless and now with our chronic disease management initiatives. Over the past three years, the organisations have had to make considerable efficiency savings, so those savings have been used in other ways to start to change the way in which care can be delivered. They have had to save quite a lot: up to about 9 per cent this year, accumulated over the past three. So, resources will have been released, but they will have been ploughed back or released to the central pot, because of a requirement for efficiency savings to cover other increases in expenditure, such as expensive drugs, throughout the system. It is not as easy as saying, 'Good, we have reduced our admissions by 12 per cent and length of stay by X, and so this is pot of money will go over here'.

[43] **Eleanor Burnham:** We all understand that, but it seems that many reports are pointing to releasing money so that we can improve community services. My next question is to Dr Goodall about the LHBs and working with the trusts to identify resources that could be freed up and redirected at community services. Are there any major barriers to transferring resources from the hospitals to communities, and are they difficult to overcome, which I suppose follows on from what Ann Lloyd has just been saying?

[44] **Dr Goodall:** This is a critical aspect of the report, namely how we achieve change. All of us who work in the service want to ensure that people receive the right service at the right time. Perceptions about the location of the right services are often difficult. For instance, on public perceptions, when given the choice of a hospital bed versus a community service, people will often choose the hospital building. When we have conversations about where care is best delivered, people start to talk about the opportunities of receiving their care closer to

home and perhaps in their locality. It is difficult to find ways in which resources can be transferred, and, in part, that is because we need to demonstrate that these schemes and new services work effectively before people will really trust that you can step down on the existing, traditional services.

1.50 p.m.

[45] I will give you a local example that relates to support for this particular set of clients and patients. In the Neath Port Talbot locality, we closed a community hospital, but, to do that, we were required to show in advance that community services were in place that could provide better quality care. That allowed us to have a proper discussion with the community, which was reassured that the alternative was a better option. The question that I think must always be asked is how long do you need to manage the transition? How long is it essential to have these services being shown to be effective or not? I am thinking of colleagues elsewhere in Wales, and I know that the challenge for them has almost been to take down the existing service first before creating the community service. There is a real difficulty for us there.

[46] As far as our local discussions are concerned, a lot of the local work that we have done in partnership in Bridgend and Neath Port Talbot is predicated on the basis that we would probably find, if we could line up the appropriate services, that 25 per cent of patients are in the wrong bed at the wrong time. That is supported, of course, by 'Designed for Life', the NHS strategy. To answer your question very honestly, it is difficult to get to the resources. On paper, it sounds fine, but resources really mean dropping down the number of beds in the locality to create alternative services within the community, and that is difficult to deliver.

[47] **Eleanor Burnham:** I suspect that the sparsity of the existing provision in rural areas could well lead to a campaign by people who do not want to lose even that provision, because they are fearful that they would then be in a worse position.

[48] **Dr Goodall:** I think that it is right to accept that people will be fearful of that. That is why the challenge for us, working in the NHS, is to make sure that we engage properly with the public, describe the alternatives, and give those reassurances. In my experience, I found that having conversations over time with relevant groups, stakeholders and individual members of the public was the way to build up trust in the proposals that we had for our area.

[49] **Eleanor Burnham:** Perhaps it is about working with the media because, after all, that balancing act is always an issue for us, as representatives.

[50] **David Melding:** Dai, you had a point to make on service development.

[51] **David Lloyd:** To develop your argument a little on the pressure on beds, when we talk about acute unscheduled care, we are talking about secondary care beds that come under trust control and trust finance, but when we talk about community services, we are talking about LHB finance. That is why I think that there is a general perception that, if a saving is made in beds for the trust, that new money will not necessarily be transferred automatically to the LHB to develop community services. That is the perception, although things may work out in reality. Could we have a short comment on how you convince people that savings in a different organisation translate into extra moneys for you in reality?

[52] From a trust's perspective, there is always pressure on beds and, traditionally, we have gone with an 85 per cent bed occupancy rate as the optimum rate, given that you need a bit of flexibility to account for unexpected happenings such as winter flu epidemics. To have 100 per cent of your beds occupied all the time would be an inefficient way of managing the system, although it can be difficult to justify empty beds, in auditor general terms, as it were. They are seen as just lying there waiting for someone to fill them up at random. How do you

manage to square that particular circle? Given the downward pressure on beds and the need to release beds and so on, how do you balance that against the fact that we need empty beds?

[53] **Ms Lloyd:** I will take that bit first. It is accepted practice that, in the acute hospitals, we try very hard not to go above a bed occupancy rate of 85 per cent, because there is a very rapid turnover for many of those beds. We have to channel those in-patient beds, rather than day beds, that are filled for less than 24 hours. What was the reason for that? Could people be managed in a very different way? When you look across the board at the totality of bed occupancy in a location or within a whole trust area, you then see that they are not all running at 95 to 99 per cent. There are inefficiencies in the service, and you come on to it helpfully, further on in this report.

[54] There is an issue about how community hospitals operate, how well they are used, and for what purpose they are used, and although it does not feel like it, they could be the slack in the system that could be more purposely directed. I think that you can justify some empty beds in organisations, because they will soon get filled; it is getting the right flow through the system that is really important.

[55] The trusts, as you know, also manage the community service. Although, traditionally, secondary care has absorbed a great deal of the resource, secondary care also recognises the fact that, to meet the objective and provide the service delivery that only they can perform, they really do need to start being extremely creative within their community, primary and social care services to concentrate on what they can do and ensure that there is that movement through the system by means of the effective application of care pathways, which are on the web, as you know. We have to rebalance the system, and we have to do it more quickly. In many parts of Wales, the NLIAH modernisation assessments and their innovation publications, which come out annually, show that a huge amount of work has been done to redress the balance and to tackle some of the issues contained in this report and within our own strategy. It needs to be faster, however, and I absolutely take on board what Andrew says about showing the public an alternative that is really good and more effective in meeting their needs as they have expressed them, and not a knee-jerk attempt at solutions that are just not tenable.

[56] **Eleanor Burnham:** Paragraphs 1.6, 1.10 and 1.20 show a large and increasing number of people being admitted with symptoms and signs suggestive of chronic conditions. They also detail the inconsistencies that you referred to, Ann, in the way in which some trusts record admissions, which means that the true demand for services is underestimated. What steps is the Assembly Government taking to improve the accuracy and the consistency of how trusts record hospital admissions so that the information for planning is more consistent and reliable?

[57] **Ms Lloyd:** We have commissioned NLIAH to develop a methodology that will allow a comprehensive review of clinical coding down to quite a depth—beyond just the first two levels that are usually used—to ascertain what processes and support will be required to achieve greater accuracy. It is really important that asking NLIAH to develop the methodology specifically to improve accuracy will, in some instances, mean a complete audit against the clinical notes. We have to get this accuracy, otherwise you are never quite sure of the exact nature of the problem that you are trying to overcome.

[58] **Eleanor Burnham:** Dr Goodall, how can the LHBs assess demand for services and plan for alternatives without consistent and reliable information on the number of emergency and medical admissions, or are you just looking forward to what Ann Lloyd has just suggested?

[59] **Dr Goodall:** We use the information that is available. My view of the report is that it

is saying that, even if demand were higher, there is a big enough problem to resolve with chronic conditions anyway just on the numbers that are presented. If it was at the edges, then it may be of greater concern for me. Fundamentally, the report is saying that we need to change our system.

[60] With regard to the information that we use, however, speaking from experience of different LHBs, we need to include an understanding of the population's needs, working with public health in particular. I have examples of reports that we have taken through to our boards, such as one on our respiratory strategy, which starts off by describing the scale of the problem before looking at the international evidence base for how you resolve the issue. It then looks at some of the gaps and shortfalls in the local services that we have. So, there is more than enough data around to help us, but I nevertheless agree with the concerns of the committee that if there is variation in the means of recording, it needs to be sorted out in our future arrangements.

[61] **Eleanor Burnham:** What are the reasons for the increase in admissions for symptoms and signs suggestive of chronic conditions?

2.00 p.m.

[62] **Dr Goodall:** I can only give a personal view. I think that it would relate to some recording issues, potentially. We also have an increase in demand around patients coming into the system for short periods of time. Sometimes, these people are not fully known within the system, and people are still exploring the issues; if you cannot pin down the diagnosis as part of that admission, it can cause problems in how we record the data.

[63] **Eleanor Burnham:** Can you give an example?

[64] **Dr Goodall:** We have had a change of services recently; over the last 10 years or so, we have introduced more of an assessment function. The genuine intention is not to get people into the hospital system on the premise that, once in, you will probably be there for several days. Although we might well have been requesting tests, people may be fit enough to return to their home environment—and quickly—rather than just waiting in the hospital for seven or eight days. When that episode is recorded, the diagnosis for that individual patient will not necessarily have been clarified. That could possibly be resolved through a future admission, when that information has been re-provided.

[65] **Eleanor Burnham:** Thank you for that explanation.

[66] **Huw Lewis:** I wish to return to the issue of community-based services. It is clear in the report—I do not believe that anyone disputes this—that we have a week-days only problem, or the nine-to-five problem, we have a capacity problem in some areas, we have duplication in some areas, and gaps in others. What is the Assembly Government doing to ensure collaborative working across the geographical boundaries between trusts and LHBs—to look at those gaps and duplications in particular? We always ask what the Assembly Government is doing to 'encourage' trusts and LHBs; why are we bothering to 'encourage'—why do we not just require this?

[67] **Ms Lloyd:** As you know, we have published our strategy. The Minister has allocated £15 million for us to start to implement that strategy, on the basis that we need consistency across Wales. The main issues underpinning this strategy are to remove inequalities, and to ensure that there is far less fragmentation of services and that there is greater integration throughout Wales of the type of service that people can expect. There will be nuances, because of the care needs of people in various localities.

[68] Underpinning the strategy is our practical framework of what we should be doing to better manage those suffering from chronic diseases. This is a significant problem in Wales, which is growing, and we need to get a greater handle on future demands from people who have at least one chronic disease and wish to live in their communities. The next piece of work that we are doing is trying to become far more accurate about future demand. As part of this year's annual operating framework, we are requiring each organisation to produce its framework for action—its baseline survey of what the services are, and what the needs of the population are at the present time.

[69] The National Public Health Service did an effective piece of work, some two years ago, which looked at the health needs relating to chronic diseases in Wales. That was informed by the Welsh health survey, household surveys, GP records and so on, and has been built on universally throughout Wales over the last two years. We will then get a view on where inconsistencies are arising, and try to get a definition that people in communities can understand about what the names that are given to services mean for them, how they are going to access them, and how they can have an informed discussion with their GP, as their gatekeeper, to be able to access these services. The Minister has put money in to do that in each community; she has also put in resources to fund three pilot schemes. I assume that we will be returning to the pilot schemes later, so I will leave that for the moment.

[70] **David Melding:** Do you want to add to that, Dr Goodall?

[71] **Dr Goodall:** It requires leadership from within communities to recognise that they can get the collaboration going in the interests of patients in all of the different population areas.

[72] Although I am now the chief executive of both Bridgend and Neath Port Talbot LHBs, when we started working on chronic conditions management some two and a half years ago, we took the approach of working around the trust boundaries. So, it was in the interest of all of the patients locally that we looked at the gaps in services that were created. It was intended to cause fewer problems for the trust, because communicating the range of services that are available should be done in a consistent way. I also think that you will get consistency given that all areas of Wales have had to produce chronic condition action plans, which we submitted in April this year. There is a challenge in there to describe how we are taking forward some of the key issues that need to be introduced in all of the localities. As an example, we all need to describe what we are doing about a case-management approach, because we know that it works, and we know that it needs to be rolled out. So, I think that you will see some consistency from that perspective.

[73] **Huw Lewis:** I understand what you are saying, and this is all positive stuff moving forward, but it strikes me that, quite often, the NHS in Wales centrally is a bit like King John dealing with the barons: it is a little bit too nervous about what the barons might think of it.

[74] **Ms Lloyd:** That has never been a problem.

[75] **Huw Lewis:** I do not want to take this metaphor too far. We do not want you dragged off to Runnymede. [*Laughter*.]

[76] I have a supplementary question on awareness. I think that we would all, as local representatives, have come across low levels of awareness on the part of NHS staff—both clinical and non-clinical—with regard to what is out there. In taking this collaborative work forward, are NHS staff talking properly to those organisations—such as the Parkinson's Disease Society, the Multiple Sclerosis Society, the Stroke Association—which are very professional organisations that look after the interests of those who are chronically ill?

[77] **Ms Lloyd:** Helen, do you want to answer that?

[78] **Ms Howson:** Yes. We have a reasonably comprehensive framework in place to address some of the points that you have raised there. I will address your latter point first. The role of the voluntary sector is seen as being central to this. We have been working on a number of things over the last few years to ensure that the sector can work collaboratively and that we can work collaboratively with it. So, we have helped to bring together the long-term conditions alliance, which is an alliance of agencies representing a variety of individual voluntary organisations supporting those with chronic conditions. Bringing those together formed a part of informing the whole model and its shape and form. We have used their expertise for some time to inform that and also to help us to direct others to deliver and also to identify the role that they play locally.

[79] We have also established local networks, so while we have a national alliance, we also have a network of organisations across Wales within each of the 22 LHBs. We have in place health and social care facilitators who are bringing together those local networks. So, we have the two working together. Between the two, there is good communication; we listen to them and they listen to us, and, together, we work things through, because we recognise that they are very important and are central to informing and delivering the services. We also have a national implementation group, and a national user forum. We have just undertaken some research with them on the role of individual organisations across care pathways to support chronic conditions. So, there is a lot of work going on. We see them as being central to the work that we are doing.

[80] We have also used them to help to inform—and enable us to get better information—on the patient experience. It is very easy to lose sight of that when you are in the Assembly Government. We have seen that as being an important tenet throughout both the development and the continued implementation of this work. They are central to that. We have also used expert groups to talk to patients as part of that central theme, and we also involved them recently in a major piece of work in which we are trying to gather the patients' experience in this, and that information will be central to that. We really see that as fundamental.

2.10 p.m.

[81] I agree wholeheartedly with the point that you raised earlier. One of the things that we found that was consistent with our research and the Wales Audit Office report was that many things were happening, but that we needed to, somehow, bring them together. So, first, transitional funding was very specific and quite directional, and specified that we wanted local health boards to undertake a review of all services in their area and report back on that, and, secondly, that they must undertake a comprehensive analysis of all of the available information, including WAO data. On that basis, they have six months to do that this year, and they will then use that information to inform what changes and transitions need to happen in their services to improve them.

[82] **David Melding:** We now move on to Chris Franks, who has a supplementary question on this specific area.

[83] **Chris Franks:** My experience as a member of a LHB is one of disappointment in that there seems to be a constant lack of co-operation between trusts and LHBs, and there is rivalry and a protection of budgets. That might all be washed away with the reorganisation, which we all look forward to, only to be replaced with the new fear that the interests of the primary care sector will be swamped by those of other sectors. I am told that much will depend on personalities—it will all depend on people, at the end of the day. What assurance can you give me that the good work that we have been hearing about will not be lost with reorganisation? How will you ensure that reorganisation protects what we are talking about

today?

[84] **Ms Lloyd:** First, we will have captured this year the status of each of the communities and their plans for the future. One thing that we must do, through the transition directors—and Andrew is one of those—is to sit down with the whole of the community that will form the new local health board to look at consistencies between the former LHBs and their plans and proposals, and to come up with a structured plan of how the chronic disease management framework will be taken forward between them over the next three years. They must justify the resources that are being put into them to effect changes in the way in which chronic disease management is exercised in their regions and between regions, because there must be consistency. We must be sensitive to individual needs, but we must really work hard to remove and reduce the fragmentation in the services that currently exist. They are all currently doing their legacy plans, and we must capture the real stars, which are performing at delivering much better chronic disease management systems for patients and carers and to ensure that those are rolled out throughout Wales. Underpinning all of this is the need for a new structured way to develop and train the workforce so that they can move from one environment into the community, and to be able to work more effectively with colleagues in social services, the voluntary sector, and so on.

[85] So, the transition directors have a major job to do to ensure that there is a focus and a concentration on this. Primary care has a big role to play within these new organisations, and this is the first opportunity that we have had to ensure that primary care really does become a very full partner in the delivery, planning and development of care within a big locality. As part of the chronic disease management framework, co-ordinators will be appointed to work with clusters of general practices. Those will cover 30,000 people, possibly, so they will not be huge, but the co-ordinators will work with the clusters, and then with the single co-ordinating, multi-disciplinary team, to effect a change in the way that care can be accessed.

[86] So, I am well aware of the fears of the British Medical Association, and of general practitioners in Wales. We have had very full discussions about this, and we are mindful of the BMA feeling that it might be pushed to one side and just told what to do in the future. That is not part of trying to get this much more integrated system working. However, we have to be careful.

[87] **Dr Goodall:** Those problems across organisations have not been experienced everywhere in Wales in the way that you described. I accept that there have been communities that have struggled to focus on some individual issues. From my perspective over the last three years, working in Neath Port Talbot, we have delivered a number of different initiatives across the LHBs and the trust—both when it was Bro Morgannwg and Abertawe Bro Morgannwg University NHS Trust—on waiting times, chronic conditions management and emergency care. We have tried to take down some of those barriers in the interests of individual patients receiving services, rather than get into a tennis match, as it were, between organisations.

[88] On the primary care issue, we should recognise that, as the report states, 80 per cent of people's experience around chronic conditions is already managed by general practitioners in the community. We have an opportunity to re-emphasise that and reinforce it. One of the positive aspects of the new GP contract, from the feedback that I have had from general practitioners and patients, is the introduction of the annual chronic condition clinics. Effectively, everyone goes in for an annual MOT for heart disease, for example. We are starting to keep on top of this and manage people's risks far more proactively. However, there is more that we can do in primary care as well.

[89] **David Melding:** Huw, would you like to take question 5?

[90] **Huw Lewis:** Yes. I wanted to ask about those at risk of readmission. The identification of those at clinical risk of readmission is of obvious benefit. However, we are not doing it right. Does the predictive risk stratification model, PRISM, hold the answer to this? If so, when can we expect it to be operating across Wales?

[91] **Ms Lloyd:** PRISM is a tool to help us manage. It is not the answer, because if it is not used, it cannot do anything. However, it is an extremely useful tool, it is evidence based, and it tells us, for example, that if we manage the riskiest 20 per cent proactively, then we can avoid a huge amount of distress within individuals' care, and the readmission rate goes down. It is all down to a knowledgeable assessment of the risk that affects each individual within the community, and then a very proactive response to managing that risk more effectively. Do you want to say anything on that, Helen?

[92] **Ms Howson:** We have been developing PRISM for the last 18 months. You may not be aware that it has been based on two years' retrospective primary and secondary care data, brought together to build an algorithm that gives us the basis of that risk. Essentially, the answer to your question is that PRISM ought to be the solution, if it is used effectively. We have piloted PRISM in three areas, and Neath Port Talbot was one of the early pilot areas. We are now rolling it out to our three demonstrators, to look at the practicality of it. PRISM offers us the opportunity, for the first time, to look at populations and identify them in larger chunks of risk—levels 1, 2, 3 and 4. Once you have that, you can start to look at those populations, understand who they are, where they are, what their service needs are, and start to manage them within the resources that we have available, either within the community or combined with primary care. It provides us with an opportunity to predict risk, and to avoiding being on the back foot, as we sometimes are. It is about looking forward, being proactive and anticipating needs, so it has all those elements. We are looking to roll it out over the next 12 months, and we then have to ensure that it is used effectively in that way, not only to manage risk, but to predict risk in a way that prevents us from being reactionary.

2.20 p.m.

[93] **David Lloyd:** Turning to the expert patient programme, empowerment of the patient is all the rage—[*Laughter.*]

[94] **David Melding:** You said that with some feeling.

[95] **David Lloyd:** I merely quote prevailing opinion. Compliance with management is a lot better when patients are involved in that management, so expert patient programmes are, in general, a good thing. The auditor general's report highlights the fact that, given that these are a good thing, there are not enough of them. Can I push all three of you a little further on that feel-good factor, namely that everyone acknowledges that expert patient programmes are a good thing, and ask what hard, clinical evidence you have of their effectiveness at improving an individual patient's care management pathway? If you have robust data to say that expert patient programmes are pivotal to improving patient care, why are there not more expert patient programmes? Conversely, if you do not have the evidence to say that they are a fantastically good thing, why do you have expert patient programmes at all?

[96] **Ms Lloyd:** Helen will answer on the issue of the evidence, but, on expert patients, when we started to deliver the programme for this chronic disease management framework, we had a number of workshops, which involved secondary care consultants, general practitioners, social service leaders and so on, and also expert patients. The difference in the dialogue, and the way in which you would design your services, given the information and the evidence produced by the expert patients about how they could better access care and fulfil their desire to have more control over their condition led us to reform, almost, the way in which chronic disease management was developed for the future. They were very articulate

and clear about what, from their point of view—they were supported by a whole group of people with a similar condition—worked and what did not work for them. There were very clear about the circumstances in which they did not wish to find themselves, and about their ability to self-manage. So, from the point of view of not only empowering, because that is just a flashy word, people to take control of their condition, but allowing people to be better educated and informed about the consequences of their condition, it was helpful to us by starting to redesign and modernise the way that care could be delivered. Having said that, Helen will deal with the evidence issue.

[97] **Ms Howson:** There was an independent evaluation in 2007 that recognised that EPP provided benefits to a proportion of people. The benefits were mainly on self-efficacy, and there was evidence to suggest that there was greater self-management. In answer to your first question, I do not see EPP as a panacea, so we should not put all our eggs in one basket. Such programmes are part of a suite of tools that we need to make available, and we have produced a paper that provides a more strategic framework on self-care. Some of us sitting around this table might wish to go to a structured education class, such as EPP, others may want to do it on our own in a room, on the web or whatever. So, the framework that we have developed, on which we intend to build over the next year, is based on four elements. One is around skills training, and the second is around assistive technology, because, as you will appreciate, telehealth and telecare are all about helping people to self-care. The third element is around self-care information and signposting.

[98] We heard a lot from our expert patients that a large part of the problem was that they could not find their way around the system or find the information that they wanted that was reliable and consistent. That is something else that we are looking at. The fourth component is around the self-care support networks. As we know, there are already lots of networks and support groups, and we need to be able to ensure that people can join those should they wish to. So, the essence is really around having a basket of tools that we need to ensure are available and accessible to everyone.

[99] **Dr Goodall:** Local health boards have been building on the experience of the expert patient programme over the past couple of years or so and we are expanding and developing it. Although we evaluate those programmes locally, looking at that from a board's perspective certainly really brings home the impact of providing education and support to people. Many of the interesting discussions that we have had at a board level have really been quite personalised accounts from people who have used these kinds of services and found support.

[100] I would agree with what Helen was saying. If we said that this was the only solution, that would be wrong; it is really about trying to develop all sorts of different opportunities. There are education programmes, for example, that can be put in place for people—there has been a particular focus on diabetes across many of the LHBs in Wales. There are opportunities to provide additional training to primary care professionals, GPs and practice nurses around this area. We are also linking with other initiatives. I do not know whether you are aware of the Pathways to Work schemes that are currently being overseen. They are focused on chronic condition areas and, again, support people back into a work environment by giving them confidence and support. Underlying all of this, for me, is the fact that self-care and giving individuals the confidence to feel that they can self-manage and be independent are critical. To go back to some of the earlier points, locally, we have used the third sector to lead on self-care initiatives and to tell us how the services need to change and be different.

[101] **David Lloyd:** May I drill down a little further? In the auditor general's report, there is a statement that we need more expert patient programmes, given the tide of chronic disease that we face. Correct me if I am wrong, but the impression created is that you appear to be lukewarm about that idea of bumping up the numbers of EPPs that are in your basket of tools or whatever. I am quite happy to run with the plethora of patient groups and self-help groups

that we have because they do a fantastic job—I am not just saying that because I am the vice-president of a couple and the vice-chair of another couple. Given that plethora of schemes, for want of a better term, would you want to see more expert patient programmes, because that is the implicit idea here, as well as everything else being as it is?

[102] **Dr Goodall:** Yes, we would.

[103] **David Lloyd:** Are you looking to drive up the number of expert patient programmes?

[104] **Ms Lloyd:** Yes. Anybody who feels that they could really benefit from that should be given the opportunity.

[105] **Chris Franks:** I will move on to part 3, paragraphs 3.2 to 3.4. There is reference to the fact that the planning of services was undermined by a lack of consistent assessment and so on. Mrs Lloyd, what action—I stress the word 'action' in view of Huw's earlier comments—is the Government taking to ensure that the future planning of services is underpinned by a thorough analysis of population, health needs and the demand for services?

[106] **Ms Lloyd:** We have, as the baseline, the National Public Health Service for Wales work on the assessment of the population in relation to chronic diseases. That work is being taken forward on a locality basis by the NPHS to ensure that it is updated on a very regular basis, so that we are clear in our health, social care and wellbeing strategies that the requirements for the management of individuals with chronic diseases—particularly those with multiple chronic diseases—are being effectively tackled within each of the localities. By 'locality', I mean an area no bigger than an LHB area. We have to retain the nuances or people will just get a universal service that might not meet their needs.

2.30 p.m.

[107] The transitional funding that we have given to the local health boards requires them to analyse the data that they have on the needs of individuals in their communities and to present an action plan. Currently, we are somewhat hampered with regard to information: we have a great deal of secondary care information, and we have access to the general practitioners' information, but to make this a really consolidated piece of work, we need better access to social care information, and to that end we are now bringing in the accident and emergency statistics for a much broader view of the data and data outcomes for more effective analysis.

[108] Quite a lot is going on at the moment. The predictive risk stratification model is being developed for each of those communities to see where the top 20 per cent of people are. Because the transitional funding—which is deliberately termed as such—is very focused, we have established three pilot areas to look at the way in which services change to deliver this self-care assisted technology more effectively and to examine the changes that are required to ensure that people are not just admitted to hospital—that our community hospitals become much more proactive when intervention is required. Those pilot schemes are up and running and they are being evaluated now to ensure not only that the plans coming in from the local health boards might effect change, but that best practice as evidenced in those three pilot schemes is shared throughout Wales. The three pilot schemes have been chosen to cover very different types of areas so as to cover the piece in Wales.

[109] **Chris Franks:** You said 'social care'. Does that include county councils?

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

[111] **Chris Franks:** That opens another arena. We often hear about the conflict between

social services and health. Have you a solution to this?

[112] **Ms Lloyd:** Let us take the example of somewhere that I do know about, which is Carmarthenshire, where I was on the local service board until recently. There were huge problems with co-ordinating services between both bits of health—let alone health and anybody else—and the local authority. We decided to put a chronic disease pilot in place there, and through it we have started to overcome some of the fairly entrenched and deep problems of what we shall not call 'protectionism', but rather 'holding on to one's assets' because we had a job to do. We wanted to focus on a more holistic approach across a set of communities by combining our resources to tackle the problems facing us, particularly with regard to delayed transfers of care and the management of those with chronic diseases—two sets of individuals who are synonymous with each other in many instances.

[113] In that case, the local authority and the health boards first and foremost drew up a joint plan. They had to be clear about what could be expected of each of the partners; they did not impose objectives that simply could not be met by the partners concerned. They then started to have joint appointments, and they started to have much better joined-up needs assessment right across the piece. Only then were they able to start to move away from more traditional models of care to a suite of services. We are just beginning at the moment.

[114] The whole environment and atmosphere, driven very much by the leader of the council and leaders in the local health board in particular, have really changed. Real willingness and activity on the ground has come out of that more holistic joint approach, with all parties understanding that we have to tackle this problem together: these are the issues that we can solve collectively; this is the money, so we know what we have; and these are the outcomes that we can all sign up to. It has to be driven, and leadership has been vital in that area to get across and over the tremendous barriers that existed before. I think that we got to that stage because, certainly, the leader and I knew that the environment had to change to effect an improved service on the ground.

[115] You will see, as we run through this chronic disease management pilot schemes in Carmarthenshire, the major steps forward being taken by really creative people working for the local authority, and the local authority, the local health board and the trust. Real change can take place if people co-operate and are honest with each other and really make an effort to make a difference.

[116] **Chris Franks:** That was a very enthusiastic response.

[117] **Ms Lloyd:** I am enthusiastic.

[118] **Chris Franks:** That is good to hear. However, is it not tragic that this has not been happening for many years? It is perhaps only in the recent past that we have addressed this. How many casualties have there been because we failed to do this?

[119] **Ms Lloyd:** Exactly—and that is why there is such an imperative to put enormous energy into the implementation of this framework. People have co-operated well in various parts of Wales in the past, and Wales should be praised for at least recognising that this is an important issue that needs to be tackled by and between the stakeholders. The voluntary sector has played an enormous part in delivering the solutions in Carmarthenshire and throughout the rest of Wales. We have been stymied by a traditional approach, and that is true of England as well. However, we understand the issues relating to chronic disease and its management in Wales, and we have enunciated those issues and the problems that we really will face if we do not tackle this—the growing demands of people with chronic diseases in Wales. The partners all appreciate and understand that, and that is why there is a tremendous energy being put into this, throughout Wales and between the partners, to deliver a much

better solution, with and for clients in the community and their carers.

[120] **Eleanor Burnham:** Moving on, and capturing your enthusiasm, pages 36 and 37, and in particular paragraphs 3.5 to 3.9, show that the development of community services has been fairly ad hoc because of a reliance on short-term funding, with limited consideration of long-term viability. My question is to Ann Lloyd: will short-term Assembly Government funding continue to be used for pump-priming community services development? Could the NHS bodies be doing more to secure sustainable funding solutions to support community-based services—possibly encapsulating what you have been talking about?

[121] **Ms Lloyd:** First, I will deal with the Wanless moneys. Those moneys are not short-term, but ongoing and ring-fenced for the communities. They were put in against plans to assist and facilitate an improvement in community-based schemes and an increase in the numbers of those schemes. Those are being evaluated, but I have asked for a second evaluation, and Helen is taking that forward.

[122] The money was there to stimulate more independent living, and to stimulate better working together between the stakeholders to solve the problems coming through from the needs assessments, to which they all had access.

[123] Many organisations will say that, in order to change their services, they need pump-priming money, and, originally, Wanless was pump-priming money. However, that is no longer the case—it is now mainstream, ring-fenced funding. However, quite frankly, that is only partially the answer. We have to look at how we are using all our resources at the moment. How are community nurses being deployed? Where is their work focused? What is the balance of care within community services at present? Our data are not as good as we would like, but are we using people effectively? Are we channelling our resources at those at greatest risk? This new resource that the Minister has allocated is deliberately called transitional funding.

2.40 p.m.

[124] We expect to see a transition from the traditional ways of working to ways of working and services that better fit a longer-term future for the management of care in the community. That is why we are being quite directing about how the money will be spent, and we will have more evidence when we get the results of the pilot schemes. The auditor general has put in some helpful information here about community hospitals, which are a huge resource. There are a heck of a lot of them. I expect organisations to be able to prove to me that those resources are being used to the maximum, because if you look at figures 13 and 14, you will see that only 58 offer physiotherapy, and yet 90 per cent of them are supposed to be delivering elderly care, rehabilitation and convalescence. How can they be doing that effectively if only 58 of them offer physiotherapy? We must channel attention towards the huge resource that is out there and towards the great willingness on the part of individuals working in the service to deliver good-quality care. The way in which we are using our resources must be attacked.

[125] **Eleanor Burnham:** I agree with you, and yet the irony is that Llandudno General Hospital has been downgraded by stealth over the past five years. That is contrary to your view, and to the needs and expectations of the general public. It took a lot of fighting by politicians across the parties, in the run-up to the last election, to ensure that Edwina—bless her—saw the light. However, services have been stealthily and constantly downgraded, so how can you say what you have just said?

[126] **Ms Lloyd:** I cannot comment on the stealth of what has been going on in Llandudno, but I can say that you must be clear that you must deliver really high-quality services

wherever you happen to live. In Llandudno, we asked for a review of how that important resource could serve its fairly wide population, and Frank Burns was clear in his recommendations about the services that would really benefit the population. That is the right way to do it: to have an open and frank discussion. We have to deliver safe services, and services have to be accessible and cost-effective. They have to try, with others, to meet the needs of the population.

[127] **Eleanor Burnham:** If I may, I will ask another question, with your indulgence, Chair. In north Wales, we never felt that the secondary care review was anything but a paper exercise. Some of us were horrified, because there were major issues, such as transport, which were not factored in. To take Llandudno as an example again, in the height of summer, its population is at least double that in winter time, which is an issue, and then you factor in the arterial trunk road of the A55, which is like a washing machine—when it functions it is great, but when it malfunctions, it has a huge impact on the transportation of patients or whomever. In view of what you have just said, I must ask whether you are serious about this. If you are, that is great, but if not, let us be—

[128] **David Melding:** We are focusing on—

[129] **Eleanor Burnham:** Yes, I know. That was just by the by, as it is my last meeting.

[130] **David Melding:** There was a relative shift of balance from the acute sector to the community sector, because the previous balance appeared not to be optimal. At the heart of this question lies the fact that you have tended to use short-term funding mechanisms, which has been public policy for at least 10 years, as far as I know, but we need more oomph in the community sector. Which mechanism will achieve that? Short-term funding streams do not seem to have been effective so far.

[131] **Ms Lloyd:** No, and I agree with that, but it is important that we have directed this last tranche of money at a specific set of initiatives, which we intend to embed in the community to allow those changes to take place. On Eleanor's point about the secondary care review, the whole purpose of asking Chris Jones to look at the community service was to look at whether there was an holistic and comprehensive review taking place of how you moved care to meet the needs of people or whether you just concentrated it in the secondary care service. That is why the Minister, having read the secondary care review, sent Chris Jones to do the other piece of work about what care is like in the community. It is that more comprehensive planning that is really fundamental, and you will see in the consultation document on the reorganisation that a heavy emphasis has been placed on the better planning of services and on the finance coming to underpin it. We do not want to give short-term funding. Although it is not short-term funding anymore, Wanless has shown us that it has to be more purposefully applied. Some places used their Wanless moneys really well, but it was too variable and, in this reorganisation of the health service, we have to think about how it can be better applied to meet the needs of the people.

[132] **Eleanor Burnham:** Dr Goodall, in your view, what challenges do the LHBs face in securing services that are viable in the longer term?

[133] **Dr Goodall:** I think that there have been some issues around organisational boundaries, which were alluded to earlier. Of course, with reconfiguration, perhaps some of those concerns will disappear, because it will be the responsibility of the new organisations in Wales to take those things forward. I think, for me, it is about trying to move from the language of unlocking resources to making it happen. I gave some of my personal views on that earlier, about the need to work with people to make sure that we have alternative services. Some of these changes can be very large scale. We are working locally on an integrated community-based intermediary care service, with social care colleagues, and we

intend to roll the service out seven days a week. This has already quantified what we think the impact will be on beds across the system, but we are also trying to make it happen so that we can show that it is successful, rather than people seeing just the risks.

[134] I also alluded earlier to the fact that, in closing a facility, we freed up resources that could be recycled in the system to invest in community services. Although these are large schemes, we also have a number of small examples across Wales. I know that Anglesey Local Health Board has redesigned its podiatry service so that, rather than the service going into the traditional hospital sector, nursing staff have been trained to do the work out in the primary and community-care sectors. We all have a responsibility, as managers and professionals working in the service, to make all this happen, because the recommendations in the WAO report are right, and they are consistent, in my view, with the national framework that has been set out in Wales. We have to step up to the plate and make it happen on a local basis.

[135] **Lorraine Barrett:** Ann, you started to mention funding being put in place for various projects. I am looking at the £15 million of transitional funding in paragraphs 3.10 and 3.11. How did the Welsh Assembly Government decide on that figure to help health communities to shift the balance of care between hospitals and the community setting? Are you confident that that funding will make a difference? Part of the funding is for the demonstrator sites, and I wonder whether you could tell us what has emerged from them so far.

[136] **Ms Lloyd:** You can always absorb whatever money anybody throws at you, but we felt that, if we had £15 million, we could focus on ensuring that we had co-ordinators and their teams as conduits for referral in each local area, which would start to make a difference. It is also to ensure that there was a thorough benchmarking of the service that is available at the moment, and to look at how the maturity matrix that is referred to in here might be affected. We did not want to be greedy in any way—resources are tight, as we all know—but we felt that that would be an appropriate and cost-effective way of starting to make the difference. We also put money aside for the three demonstrator sites, which are in Gwynedd and Wrexham—which are linking up as one—Carmarthen and Cardiff, which is the urban area with a different mix of needs from those of the other areas.

2.50 p.m.

[137] In those pilot schemes, we have been looking particularly at the sort of service that there is at the moment, as informed by the benchmarking work, and the description of the type of service that our expert patients and professionals are telling us will be possible in five years' time. We are then seeing what changes will be possible in the service, in information technology, in better partnership working, in engaging the stakeholders better, in service improvements, and particularly in workforce planning and the way in which our workforce is deployed.

[138] What changes will be needed? Do we need double running costs at any time during this technical exercise? How will we work together better to deliver this on the ground? We have asked the National Leadership and Innovation Agency for Healthcare to put in place a national event in spring 2010, when the demonstrators are halfway through, to look at the results so far, so that they are rolled out to the whole country. We have also been developing what we are calling 'commissioning directives', but which are models of service, particularly for arthritis, epilepsy and pain, and respiratory diseases, to inform the change in care delivery. It is in those areas that we have had the most expert patient programmes going through, so the data are more readily to hand. In addition, we have been looking at the take-up of enhanced services under the general medical services and the pharmacy contracts to see how they are playing to a reformed model of delivery for chronic disease management. All these things are coming together, and NLIAH will have this spring conference for the results so far in 2010.

[139] **Lorraine Barrett:** Dr Goodall, I do not know whether there is a simple answer to this question, but what does your health community need to ensure that an appropriate range of community services is in place for people with these chronic conditions?

[140] **Dr Goodall:** First, it needs to have the commitment of local agencies and stakeholders to work together. We have that in the area that I am responsible for. We need to be challenged on the alternative services that would be better. As I said earlier, I see not only the community view, but also where the voluntary sector can really help to point out where some services are not really delivering.

[141] It would be wrong to say that we do not need resources. The money being made available across Wales is to be welcomed in pursuing the agenda, but I do not think that we can wholly rely on that money. Much of our resource is currently tied up in services, and, although they make sure that people are treated, it does not necessarily mean that they are being treated appropriately, at the right time, in the right place, and by the right professional. Irrespective of the central money being made available, our responsibility is to redesign services that give individuals what they need at the different stages of their care pathway. Those are the three areas.

[142] **Huw Lewis:** I have a question about data gathering, and financial data in particular. The report tells us that not all NHS bodies have reliable information about how much their services for people with chronic conditions cost. Therefore, any kind of study of value for money is not possible. Will we move to a situation in which we do have reliable information across Wales? If so, how and when?

[143] **Ms Lloyd:** We do have quite a lot of data, actually, about the cost of services, because trusts have to prepare annual specialist and community cost returns that come in to us. Those returns include information about the types of services that are delivered in the community. We then use those data to develop an index of trust efficiency. We have just completed that for 2007-08. It is not yet out, but it is due to come out very soon.

[144] As part of next year's review of the reorganisation of the NHS, the finance directors have been working together to bring about a change in how reporting is undertaken so that you get service line reporting to give you a much better analysis of the costs of delivering a service. That will be a huge improvement in understanding where costs are absorbed by any service but by chronic disease services in particular. You can then benchmark the costs coming through those service lines and look at where services might be more or less expensive. That will be important. In the annual operating frame, we have improved the cost-efficiency targets for the delivery of a service. We know what the trust's current costs are for community services as compared with the Welsh average. Some areas need to reduce the cost of their community services, and be more explicit about what those community services are delivering with this service specification. So, it is becoming more and more refined. However, in chronic disease management, it is important that we get a better handle on the social care costs associated with the management of those conditions and do not forget the cost of some voluntary contributions to that. So, all that work is going on at the moment.

[145] **David Melding:** Irene James has been waiting patiently to ask her questions.

[146] **Irene James:** Thank you, Chair. Paragraphs 3.21 to 3.28 describe some of the weaknesses in relation to the planning and co-ordination of services for people with chronic conditions. What is the Welsh Assembly Government doing to ensure the success of the integrated model and framework for the management of chronic conditions?

[147] **Ms Lloyd:** We have asked for this work to be done on the framework for this year and we will then put in place the co-ordinators and their teams to ensure that care is co-

ordinated and delivered more effectively over the next two to three years. We look carefully at setting targets for the better management of chronic diseases. We felt that being technical about such a target could lead to some perverse incentives. If, for example, we said that we wanted x number of patients with a chronic disease to be diverted elsewhere, you could always go for the easy ones, where there is a high volume, and not tackle effectively the need to change a service provision and a culture of how chronic disease is managed. That is why the target for this year is qualitative so that we can establish the benchmark, come forward with a proposal, and be clear about the services and what you do about them, rather than say that we want the length of stay to come down in these conditions by x. We could not track a change of culture or a change in service delivery through such a mechanism, which is why we have not used traditional performance management levers to make the changes. We are trying to make a qualitative improvement rather than just a quantitative one. Perhaps Helen could tell you more about what we have had to do.

[148] **Ms Howson:** It has been quite complex. We have been looking at how we can clarify this for the last few years. As Ann has mentioned, we have a comprehensive maturity matrix in our service improvement plan. We have already established our baseline on that and we will be looking at it annually. We will also look to triangulate that with existing data, for example, on the more traditional length of stay, emergency admissions and so on, to ensure that the processes, which are outlined, are also linked to the outcomes.

[149] We are also ensuring that we address community services information. We are in the process of undertaking a comprehensive review of that by trying to identify appropriate clinical, service and financial indicators as well as our patient experience indicators, because if we are to get a grip on this, we need much better information on each of those elements. We are trying to answer two questions: what information do we need and why do we need it? We should have a much better idea of that by March. That piece of work will be completed, and is using some of the developments in Carmarthen as a test and to try to answer some of those questions.

3.00 p.m.

[150] **Irene James:** Dr Goodall, in your view, how easy will it be to establish and embed the integrated model and framework for the management of chronic conditions across your health community?

[151] **Dr Goodall:** I hope that it will be very easy. When the framework came out, it reflected local approaches that we had taken, as I said earlier, about engaging with partners, focusing on very vulnerable people, and trying to improve co-ordination. I remember taking the document to my board and saying, ‘The good news is that this is consistent with what we have been trying to do’. Generally, in Wales, the framework has been welcomed and it has given a clear focus around chronic conditions management. The profile of this is raised with boards across Wales—whether they are trusts or LHBs. Given that it is based on international evidence—in fact, I would say that it improves upon it—it gives us a good framework to try to respond to. I want to focus on how we interpret that on a local basis. So, for the moment, it will be about how trusts and local health boards do that within the existing model, and from some point next year, it will be how the seven new organisations take on that responsibility. I commend the way in which the framework has been received in the service.

[152] **Irene James:** Thank you. Dr Goodall, how long do you think it will take to change the balance of service provision for people with chronic conditions?

[153] **Dr Goodall:** We are dealing with issues of culture around how you change services internally within the health organisations. Obviously, people may still have concerns that some services are best delivered through a hospital setting. As I said earlier, we have

responsibilities to engage with communities and the public. So, we do not just go out and tell them how services will change, rather that they see that they are involved in the shaping and planning of these. It is always difficult to know when you have made a difference to services. With chronic disease management, looking at prevalence, these are often things that are measured in 10 or 20 years' time. In Neath Port Talbot, we have high levels of chronic disease, and about a third of our population reports long-term illness problems. However, I hope that, in a very short period of time, we will be able to describe how individuals and services have improved over the next year or two, because we will have evaluated those individual services. I also hope that the foundations that we are putting in place will show that we have made a difference in 10 years' time, which is the real opportunity for us.

[154] **Irene James:** Thank you. I think that I get to ask the final question of Mrs Lloyd.

[155] **David Melding:** You do indeed, Irene.

[156] **Ms Lloyd:** It will be one that I cannot answer.

[157] **Irene James:** I hope not. I have been with you now on two Audit Committees, so it is a privilege to ask the last question.

[158] Pages 11 to 13 set out the auditor general's recommendations. My question is a little bit naughty: how do you think that the auditor general's recommendations will be taken forward?

[159] **Ms Lloyd:** They greatly reflect the actions that we are taking. So, I do not think that we have had to wait. There has been an ongoing dialogue between the Wales Audit Office and us as the work has been undertaken, because it has been very helpful to inform the development of the frameworks. I could not have written it better myself, really. [*Laughter.*] So, I think that we are happy.

[160] **Irene James:** Will the forthcoming NHS restructuring provide opportunities or present difficulties in reshaping services?

[161] **Ms Lloyd:** I think that it gives us huge opportunities and will draw in more tightly our partners and stakeholders. It gives us a real opportunity.

[162] **Dr Goodall:** I agree. There may be some concerns about larger health organisations. For me, the relationships that we have formed around localities and with our local stakeholders absolutely have to carry on in the new organisations. However, it is definitely an opportunity to deliver the balance of the traditional acute service and move it on to the primary and community context.

[163] **Irene James:** The last question was not that bad, was it?

[164] **Ms Lloyd:** No, it was not.

[165] **David Melding:** I thank the witnesses. Obviously, that brings to a conclusion the questions that we have prepared for you this afternoon. Thank you for your answers and for giving us clear evidence to help with our deliberations. You will receive a copy of the transcript. Should there be any transcription errors, you will be able to point them out. Thank you for your attendance this afternoon.

3.05 p.m.

Cynnig Trefniadol
Procedural Motion

[166] **David Melding:** I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[167] I do not see any objection.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 3.05 p.m.
The public part of the meeting ended at 3.05 p.m.