# Cynulliad Cenedlaethol Cymru
# The National Assembly for Wales

## Y Pwyllgor Cyfrifon Cyhoeddus
## The Public Accounts Committee

## Dydd Mawrth, 24 Medi 2013
## Tuesday, 24 September 2013

**Cynnwys**
**Contents**



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

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

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

| | |
|---|---|
| Mohammad Asghar | Ceidwadwyr Cymreig<br>Welsh Conservatives |
| Jocelyn Davies | Plaid Cymru<br>The Party of Wales |
| Mike Hedges | Llafur<br>Labour |
| Sandy Mewies | Llafur<br>Labour |
| Darren Millar | Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor)<br>Welsh Conservatives (Committee Chair) |
| Julie Morgan | Llafur<br>Labour |
| Jenny Rathbone | Llafur<br>Labour |
| Aled Roberts | Democratiaid Rhyddfrydol Cymru<br>Welsh Liberal Democrats |

**Eraill yn bresennol**
**Others in attendance**

| | |
|---|---|
| Mark Jeffs | Arbenigwr Perfformiad, Swyddfa Archwilio Cymru<br>Performance Specialist, Wales Audit Office |
| Geraint Norman | Rheolwr Archwilio Ariannol, Swyddfa Archwilio Cymru<br>Financial Audit Manager, Wales Audit Office |
| Huw Vaughan Thomas | Archwilydd Cyffredinol Cymru<br>Auditor General for Wales |

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

| | |
|---|---|
| Fay Buckle | Clerc<br>Clerk |
| Claire Griffiths | Dirprwy Glerc<br>Deputy Clerk |
| Joanest Jackson | Uwch-gynghorydd Cyfreithiol<br>Senior Legal Adviser |

*Dechreuodd y cyfarfod am 09:00*
*The meeting began at 09:00*

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

[1] **Darren Millar:** Good morning everybody and welcome to today's meeting of the Public Accounts Committee. Welcome back from the summer recess. As everybody knows, the committee proceedings are bilingual, and people should feel free to contribute to today's meeting in Welsh or English as they see fit. There are, of course, headsets available for those people who require them. I encourage people to turn off their mobile phones and other electronic devices, because these can interfere with the broadcasting and other equipment. I also encourage you to follow the advice of the ushers if there is an emergency. We have not received any apologies for today's meeting, but I do want to welcome to the committee Fay and Claire, who are our new clerks. We look forward to working with you both; we are delighted to have you on board.

09:01

## Sesiwn Friffio gan Archwilydd Cyffredinol Cymru ar adroddiad Swyddfa Archwilio Cymru, 'Cyllid Iechyd 2012-13 a Thu Hwnt'
## Briefing from the Auditor General for Wales on the Wales Audit Office Report 'Health Finances 2012-13 and Beyond'

[2] **Darren Millar:** This report was published just before recess. I am delighted to welcome to the table Huw Vaughan Thomas, Geraint Norman and Mark Jeffs, all from the Wales Audit Office. As you know, we have had a number of these reports over the past few years. I think it is fair to say that there are still concerns that the Wales Audit Office has regarding the management of NHS finances. Auditor general, do you want to speak to the report? We will then have some questions.

[3] **Mr Thomas:** Diolch, Gadeirydd. Before I say a few words about the health finances report, which, as you point out, was published in July, I thought that I would headline other WAO reports that I trust have found their way to Members. These include recent value-for-money studies on unscheduled care and covering teachers' absence, which I look forward to discussing with the committee over the next few weeks. We have also published a report on issues arising from community council audits in 2011-12 that sets out some planned changes to the audit of these bodies from 2014-15, and, later this week, I will be publishing a summary report on local improvement planning and reporting in Wales, which draws together issues arising from work that we undertake across the local improvement authorities in Wales in accordance with the requirements placed upon me by the Local Government (Wales) Measure 2009. I will also shortly be sending you a report on the use we have made of the £250,000 in funds which you allocated for good practice exchange and shared learning.

[4] Early in the summer recess, I also released my annual report and accounts for 2012-13. Among the year's achievements are reports on the accounts of over 800 public bodies in Wales, 14 national reports looking at value for money, annual improvement assessments of 28 local government bodies and structured assessments of all health boards and NHS trusts, and the publication of our future strategy for 2013-16. Looking ahead, I await with interest confirmation of the recruitment of members to the new WAO board, and of changes to the way in which the National Assembly scrutinises issues relating to the Wales Audit Office.

[5] To return to health finances, this is my second report on health finances. The committee took evidence on my previous report and produced its own report on health finances in February of this year. The second report updates the financial position across the NHS during 2012-13, and considers progress made in areas of financial planning and delivery of cost savings. However, in the absence of an NHS annual report for Wales, we have also sought to bring together the financial picture with a high-level overview of service performance. Finally, the report looks at the future challenges facing the NHS in Wales.

[6] On the finances, it is a significant achievement that all NHS bodies achieved breakeven in 2012-13, particularly given the scale of their financial and service pressures, although some NHS bodies required further financial assistance in order to break even. In addition, a number of the actions taken by some NHS bodies to break even are not sustainable, for example technical accounting gains, one-off savings and delaying non-urgent activity. The Welsh Government plans to introduce a three-year financial flexibility model for 2014-15 and beyond which could help to avoid some of this short-term focus, but only if it is implemented and monitored effectively. There is still considerable variability around the quality of financial forecasting across the NHS bodies. The allocation of additional funding during the year means that the Welsh Government is still sending mixed messages, saying

that no more money will be available, and then subsequently finding extra money. Positively, however, the Welsh Government used a more robust process to allocate the additional funding last year than it had in previous years, but the process still needs to be more transparent. Across Wales, delivery against savings remains generally poor. The level of reported savings has been falling significantly since 2010-11, and we have concerns about the reliability of some of the claimed savings. Most savings plans are rolled forward from one year to the next, and are not supported by detailed action plans. In particular, most NHS bodies set ambitious workforce savings targets that are not supported by workforce plans, and do not deliver the intended savings. The Welsh Government, of course, intends that the three-year service, finance and workforce plans will deliver a more integrated approach for the future.

[7] We also looked at performance in the delivery of NHS services. Across Wales, efficiency indicators, such as length of stay, are improving. There are also signs of improvement in some areas of quality, such as stroke services and healthcare-acquired infections. However, waiting times, both for elective and emergency care, have got significantly worse. Pressures on unscheduled care this year partly explain the decline in performance. Financial pressures are also factors, with NHS bodies stopping waiting list initiatives or reducing them, and also a reduction in bed numbers, potentially contributing to the high number of cancelled operations. Given the seriousness of the decline, I intend to carry out a full value-for-money review of waiting times.

[8] Going forward, I consider the current service model to be unsustainable. There needs to be a fundamental change in the way that services are provided, but the pace of change is slow. If the trend to flat cash funding continues, the NHS is likely to struggle to stem the deterioration in performance. The recurrent cost pressures continue to build, but financial savings are drying up, and service transformation is not happening at the required pace. In this financial year—2013-14—NHS bodies are currently predicting that, even after savings, they will have a £200 million deficit at the year end. It is clear that something has to give. That is why I have recommended that the Welsh Government and NHS bodies need to adopt a transparent and robust approach to reviewing priorities, and managing risks to services and issues that assume a lower priority.

[9] Finally, in terms of how the committee might want to take forward the issues raised in this report, I think that there are several areas that the committee may wish to explore further with the Welsh Government in particular. These include whether the three-year plans that are being developed by NHS bodies are of sufficient high quality to give the Welsh Government assurance that they are deliverable and sustainable; how and whether the Welsh Government can afford to frontload three-year financial, service and workforce plans, as it is likely that NHS bodies will look to make investment in year 1, with paybacks in years 2 and 3; why savings are becoming more difficult to achieve, and whether it expects previous problems achieving workforce savings to be addressed this year and beyond; why service performance has deteriorated in some areas, such as elective waiting times, and whether or how the Welsh Government intends to reverse the trend; and, finally, what can be done to increase the pace of service reforms in order to put the NHS on a more sustainable, longer term footing. Those are the issues that I think arise from our report.

[10] **Darren Millar:** Thank you very much indeed for that, auditor general. We have a number of questions that we want to ask you as a committee. I will ask the first question. You mentioned that there had been some, what I think you termed ‘mixed messages’, from the Welsh Government regarding the financial position for health boards at the start of the year. We know that additional funding was made available to health boards in December of last year, and you summarise those on page 15 of your report. You suggested that there seemed to be more science behind the allocation of that funding this year, when compared to previous years. Can you tell us a little bit about the science that was used—what were the rules in

terms of how that funding was allocated? I think that what many readers of the report will find surprising is that there were health boards such as Aneurin Bevan Local Health Board, for example, which suggested that they did not need any additional funding, but were given £10 million in additional funding, and yet there were other health boards that seemed to not get the funding that they were forecasting they needed by the end of the year. Is there any information on how that was calculated?

[11] **Mr Thomas:** You will recall, Chair, that, when the Welsh Government appeared before you in terms of last year, it pointed to the fact that there were variabilities between the different health boards—issues to do with the elderly population and so on—and they have tried to reflect that in some of the allocations. However, in the main, the Welsh Government has actually taken a much more rigorous approach this year in terms of examining the demands of individual health boards and going in to discuss their requirements with them. So, to that extent, they are much more hands on. Geraint, can you say some more?

[12] **Mr Norman:** Referring to the table on page 15, as you said, looking back at last year, it was very much 'let's share the pot out equally to the LHBs'. This year, as Huw said, it is much more based around risk. It is not purely around the financial figures; it is around future service risks for each organisation, which are not always captured in the figures in the monitoring returns. I think that we say in the report that while the process has improved, there is still some way to go; it does need to be more transparent and it needs to be clear at the start of the year what the contingency fund is, and secondly, during the year, when it is allocated out, that needs to be much more transparent as well.

[13] **Darren Millar:** Was there a formula that it applied in some way to the NHS in Wales to determine how it would carve up this additional resource?

[14] **Mr Norman:** I am not aware that there had been a formula as such; that is probably an issue you will want to discuss with—

[15] **Darren Millar:** It was literally a sort of discussion.

[16] **Mr Norman:** It was based around discussion but, as I said, it was not just about the finances; it was also about the service risks for each individual body as well.

[17] **Darren Millar:** Okay. I can see that Members want to come in here. I think we all had a bit of a sense of déjà vu when we read the report because it is quite similar to last year's in many respects.

[18] **Sandy Mewies:** What puzzles me about this is that—yes, it is surprising that some people just got more money—there was a flatline and then some people got more money just because. I think you indicate that the explanation was that there could be a knock-on effect on other services. My first thought on that, Chair, was that anything that happens like that has a knock-on effect on other services. That effect is taken into account when they put their budgets forward. I am not clear at all whether you feel that you were clear about the explanation you have been given, because I did not understand that; I could not understand anybody saying, 'Well, there's a knock-on effect on other services so we gave them this many million pounds more, but we kept the others at less.' I just do not understand it, and I did not understand your explanation either. I wonder whether you are clear about the reasons that you were given for that. Would you think that that was normal practice or not?

[19] **Mr Thomas** As I said, the Welsh Government this year was much more engaged in discussions with individual health boards. It took into account—you mentioned knock-on and service pressures—the fact that it needed, in a sense, to avoid bedblocking and so on in terms of relations with social services departments. So, it took account of all the risk factors that it

was looking at with the winter coming on, and tried to allocate the funds in a much less straight-line manner than it has in previous years. So, it was reflecting the circumstances of each individual health board as it discussed it with them. To that extent, it is a more tailored approach that it adopted last year.

[20] **Sandy Mewies:** A couple were left with a surplus.

[21] **Mr Thomas:** Which they then used for brokerage with other health boards.

[22] **Mr Jeffs:** It is useful to think about it in terms of the different approaches to risk at each LHB. So, although each individual body predicts and forecasts what it will end up with at the end of the year in relation to delivering a certain level of service performance against certain things, different LHBs have different risk appetites. So, some might be making the decision that they will break even no matter what, and that has impacts, whereas others are basing their forecasts on the assumption that they will deliver more activity or meet all of their targets. So, when the Welsh Government comes in, it tries to take a more centralised approach to apply a bit more consistency. So, with some that may have more of a risk appetite, it will say, 'Well, compared to another, you are expecting a greater deterioration in performance, so we will balance that out'. So, it tries to take that more holistic view across, I think. The reason it is an improvement on last year is that because, last year, you will see that most of the health boards got exactly the same number, whereas this year, it has been tailored to that sort of risk as well as the financial.

09:15

[23] **Darren Millar:** I am sure that we can ask the Welsh Government some of these questions.

[24] **Julie Morgan:** I accept that it does seem to be an improvement, but I share Sandy's confusion about how the knock-on effect and future risks were calculated. Were you able to do enough in-depth work to look at each health board in order to see and analyse, for example, why Aneurin Bevan had no forecast deficit, but had the £10 million given to it? Were you able to analyse that and say, 'Yes this was good planning and value for money'?

[25] **Mr Norman:** We did not go into detail on individual bodies, but that is there. We undertook the piece of work. We had discussions with the Welsh Government and looked at the information it provided as well. The other thing that we have not touched on is the quality of forecasting in the report. We highlight that some of the forecasts produced by individual health bodies are variable at best—they are certainly not consistent. They are getting better, but they are not consistent. When we pull a table together, like we have on page 15, it does look a bit stark, but as we have said in the text, it is an improvement, but there still needs to be further improvement for next year.

[26] **Mike Hedges:** I am yet to meet a consultant who does not believe that if they overspend, the Welsh Government will come and provide them with additional money. Has there ever been an occasion when overspend has not been met by the Welsh Government?

[27] **Mr Thomas:** The point that I would make in the report is that, year in, year out, the Welsh Government has, at the mid point of the year, given extra funds into the system. We are breaking a mindset and a culture that has, over the years—as you have indicated, Mike—developed the view of 'never mind, the funds will arrive'.

[28] **Mike Hedges:** I was told by some consultants over the summer, 'We have our budget, but it does not matter if we overspend because the Welsh Government will provide us with extra money either at Christmas or the end of the year'. Do you get the same sort of

messages?

[29] **Mr Thomas:** Yes, which is why we are saying that we need to have a much more consistent approach that the budgets—as one of you mentioned in the discussion with Betsi Cadwaladr—are the budgets and those are the ones that should be adhered to. Unless that kind of discipline is brought in from the beginning of the year, we will consistently be in a position where the Welsh Government has to bail out.

[30] **Aled Roberts:** Ym mharagraff 1.9 o'r adroddiad, rydych yn sôn bod yr asesiad risg yn ehangach na'r risg ariannol, ond rydych hefyd yn dweud y dylai'r adran fod yn fwy penodol o ran y meini prawf a ddefnyddir i asesu a chydbwyso risgiau. A fyddai'n bosibl i chi anfon nodyn atom ynglŷn â pha risgiau roedd yr adran yn ystyried wrth benderfynu ar yr arian? Rydych yn sôn am *bedblocking* fel un o'r risgiau, ond os edrychwn ar awdurdod iechyd y gogledd, mae chwe awdurdod lleol ynddo ac mae'r risg o ran *bedblocking* yn wahanol iawn rhwng y chwe awdurdod. Mae Llywodraeth Cymru yn rhoi'r arian hwn i'r gwasanaeth iechyd, ond o fewn yr awdurdodau lleol y mae'r grymoedd i leihau'r risg benodol honno.

**Aled Roberts:** In paragraph 1.9 of the report, you mention that the risk assessment goes beyond financial risk, but you also say that the department should be more specific in terms of the criteria used to assess and balance risks. Could you provide us with a note on what risks the department considered as it was deciding on the funding? You talk about bedblocking as one of the risks, but if we look at the north Wales health authority, there are six local authorities there and the risk of bedblocking significantly varies between the six authorities. The Welsh Government is giving this money to the NHS, but it is within the powers of local authorities to reduce that specific risk.

[31] **Mr Thomas:** Rwy'n credu bod hwnnw'n gwestiwn y dylech ofyn i'r Llywodraeth yn hytrach na fi. Gallaf ddweud bod risgiau llawer ehangach wedi'u hystyried a'u bod wedi edrych ar sefyllfa pob bwrdd iechyd ac wedi trio cymryd y ffactorau rydym wedi sôn amdanynt i ystyriaeth. Ond, does dim fformiwla y gallaf ei rhoi i chi o ran dweud, 'Os ydych yn gweithio ar y ffigurau hyn, dyma faint o bres y cewch'. Roedd hwn yn asesiad a oedd yn cymryd i ystyriaeth ffactorau weddol eang.

**Mr Thomas:** I think that that is a question that you should ask the Government rather than me. I can say that they had a much broader look at the risks and that they looked at the situation of every health board and tried to take the factors that we have mentioned into consideration. However, there is no formula, so I cannot tell you, 'If you work on these figures, here's how much money you get'. This was an assessment that took into consideration a broad range of factors.

[32] **Aled Roberts:** Rwy'n derbyn bod y cwestiwn yn fwy dilys i'r Llywodraeth, ond a allwch chi roi rhestr i ni o'r risgiau? Rwy'n derbyn eich bod yn dweud nad oes fformiwla, ond mae'n anodd iawn i ni weld a yw'r asesiad risg yn un cyflawn os nad ydym yn gwybod yn union pa risgiau yr oeddent yn eu hystyried. Fel dywedodd Julie a Sandy, mae un awdurdod iechyd wedi awgrymu bod dim angen arian arno, ac eto mae'r asesiad risg wedi creu sefyllfa lle derbyniodd £10 miliwn.

**Aled Roberts:** I accept that the question is more appropriate for the Government, but can you provide us with a list of the risks? I accept your point that there is no formula, but it is very difficult to see whether the risk assessment is complete if we do not know exactly what risks were being considered. As Julie and Sandy said, one health authority has suggested that there is no need for funding, yet the risk assessment has created a situation where it has received £10 million.

[33] **Mr Thomas:** Yn sicr, gallwn amlinellu'r penawdau fel yr wyf yn eu deall. O ran y cwestiynau ynghylch ai'r rhain oedd

**Mr Thomas:** Certainly, I can outline the headings as I understand them. In terms of the questions around whether these were the

y penawdau cywir, rwy'n credu y bydd yn rhaid ichi ofyn i'r Llywodraeth.

correct headings, I think that you would have to ask the Government.

[34] **Jocelyn Davies:** In your report and opening remarks, you have highlighted the methods used to achieve break-even. I think you said 'technical adjustments'. I guess some of us might call that accounting sleight of hand. However, you say in your report that that is not sustainable and that those technical adjustments actually resulted in £20 million of savings, even if it was on paper. You also mention that there was a significant cut on spending on waiting time initiatives and a reduction in elective activity in some of the health bodies. On those second two, can you tell us how much was saved by those methods? Since you published your report last year, and reinvestigated this year, have you seen any greater emphasis on achieving sustainable savings?

[35] **Mr Thomas:** What we are seeing this year is that the pressures have consistently been on trying to hit the end-year target. The factors you mentioned were the ones that were taken into account. They did find means, within the accounting rules, of adjusting. They did take short-term steps. That is highlighted on page 23; the impact of the elective procedures in the final quarter last year, compared with the previous years. You will see the change that has taken place. None of that really represents sustainable savings. In terms of each individual health board, I would need to write to you with our assessment. We tried to bring them together in the report.

[36] **Jocelyn Davies:** Have you seen a greater emphasis this year on sustainable savings?

[37] **Mr Norman:** We published the report in July. That was based on the 2012-13 financial year and the findings set out here. In my personal view, I do not think that much has changed. We have not seen the evidence for that, but, as Huw said, that is something that we will be following up again in due course.

[38] **Mr Jeffs:** On the waiting times initiative, it is very hard to put a specific figure on what they did not spend, if you know what I mean, and how much they would have spent had they continued with waiting times initiatives as per previous years. So, in the report, we have not sought to put a specific figure on that. What we have highlighted is that, to varying degrees, they have taken those decisions, but we have not tried to get to the bottom of exactly how much has been saved or might have been saved in a counterfactual position.

[39] **Jocelyn Davies:** So, even if you cannot quantify that, you would still stand by the report in that it is a false economy and poor value for money?

[40] **Mr Thomas:** Yes.

[41] **Sandy Mewies:** I have two questions that are linked together. I think that many of the questions that we are asking today come out of what could be kindly described as the anomalies that you are describing in your report; the fact that savings are achieved by technical adjustment, by non-recurrent savings, by moving capital into revenue—or was it the other way round?

[42] **Mr Thomas:** Capital into revenue increases, yes.

[43] **Sandy Mewies:** Yes, and things, in a large organisation, that people normally know, such as 'I am going to work year on year'. You say that there is good practice somewhere. Is there any evidence that identifies the barriers to sharing good practice? As an addendum to that, could you be explicit about where you have seen good practice, what exactly it is and how the Welsh Government could facilitate in the sharing of that good practice? Following on from that, do you have a view on the level of savings that could be achieved with a more co-

ordinated approach to planning within NHS bodies? I think that you make it quite clear about the linkages you would expect to see where the outcome would be more savings. Particularly given the fact that a lot of the fat has been cut out of the budget anyway, you may have a view or not. Do you think that it is possible and, if you do think that it is possible, how possible is it?

[44] **Mr Norman:** In terms of the good practice, certainly with all the local work that we did, which underpinned this national report, we did find lots of good practice out there. It is not all doom and gloom, if you like; there are some really good pockets of good practice that we are seeing. To go back to the forecasting, some of the NHS bodies have very good forecasting procedures, and you can see that from the charts. However, what we are not seeing is that being shared. The LHBs and NHS trusts are very inward-looking. They are not working across Wales, if you like. In terms of quantifying the impact of that good practice, it is very difficult. I would not like to put a figure on it at all, to be honest. There are examples of good practice that could save fairly small amounts and others that could save larger amounts. So, across Wales, I certainly would not want to put a figure on it.

[45] In terms of taking it forward, we have a recommendation in the report for the Welsh Government to take forward. It is probably a discussion for the Welsh Government, I suppose, but there does need to be much more of a holistic all-Wales approach to the sharing and identifying of good practice, and linked to that some benchmarking as well, particularly on costing information and service performance information. That could certainly be taken forward.

[46] **Sandy Mewies:** You mention that there were pockets of good practice in the report. Is there any obvious way that you have thought about, or a mechanism by which that good practice could be shared, and who would be responsible for overseeing that?

[47] **Mr Thomas:** There is a need for good practice to be actually managed centrally in terms of the Welsh Government picking these up, sharing them, and encouraging health boards to learn from each other. As Geraint said, there is a tendency for the boards to be inward-looking, concentrating on themselves—less so if they have to share services across boundaries. However, it is an inherent risk because each is trying to manage its own budget. There is, actually, a totality that comes together to represent an NHS budget and I would expect the Welsh Government to actually manage that and perhaps look at it more holistically.

[48] Mark, do you have anything to add?

[49] **Mr Jeffs:** I guess that, in terms of the barriers, it is probably well known that there is the ‘not invented here’ syndrome, kind of thing. I guess that there is a tendency to think that if you identify some good practice and write it up as a case study, everyone will find their way to it, copy it, and do it somewhere else. Actually, it is a much more complex process involving people and bringing people together. That is why we have recommended, in our recommendation, things like seminars and establishing professional networks for people to exchange knowledge and information and to learn from each other. It is putting in place the basic things that you need to get different organisations, and the people within them, talking to each other and learning from experiences, rather than hoping that someone will see something and think, ‘That’s a great idea so let’s cut it out and transplant it over here’, which, as all the evidence suggests, is not the most effective way of transferring good practice. It is hard work to do. That is the difficulty; it is a question of where you start. There is clearly a role for the Welsh Government in facilitating that.

[50] **Darren Millar:** Jenny, is your question on this point?

[51] **Jenny Rathbone:** Just on this, at the bottom of page 11 you talk about good practice,

[52] 'in at least one local health board'.

[53] Why is it not possible for you to mention that health board? Is there something about your terms of reference that prevents you from talking about good practice and shining a light on that?

[54] **Mr Thomas:** We do identify good practice, particularly when we carry out value-for-money studies. You will recognise that we made a few of those when you look at the unscheduled care report. This one, essentially, brings together the financial reports of each individual health board at year end; so, it reports as we have found the information. There is good practice, as we have all just commented, but we do not see from our work that the learning across is working well, particularly on savings schemes.

[55] **Jenny Rathbone:** Why can you not mention that local health board?

09:30

[56] **Mr Thomas:** We will, if you want, highlight areas of good practice in a further note.

[57] **Darren Millar:** Is there a role here, auditor general, for the Wales Audit Office good practice exchange or for something parallel to that, running alongside it, for the Welsh NHS? It seems to me that there may be good practice in the NHS that ought to be shared more widely across the public sector, but, likewise, there may be good practice in other public bodies, local government et cetera, that could be shared with the NHS and that it might be able to benefit from. Is the good practice exchange perhaps a forum by which the NHS could pick up good practice and make sure that it was implemented?

[58] **Mr Thomas:** Certainly, at present we are running a number of shared learning events under the good practice exchange on assets, including IT, fleets and other issues. The NHS is participating in that alongside everybody else; it is not restricted to one particular part of it. I can mention that Powys, for example, is developing a lot of shared IT facilities between the local authority and the NHS. That is good practice. It prevents both of them from duplicating facilities. So, the shared learning events are doing this, but right across the board. We have not run ones that are tailored specifically for the NHS.

[59] **Darren Millar:** Okay. We are going to come to Aled and then Oscar. Pardon me—

[60] **Sandy Mewies:** Can I just—[*Inaudible.*]—those notes on good practice—[*Inaudible.*]

[61] **Darren Millar:** Of course. Aled and then Oscar.

[62] **Aled Roberts:** Rwyf eisiau cyfeirio at ran 2 o'r adroddiad, sydd yn sôn am ddangosyddion effeithlonrwydd. Mae sôn yn yr adroddiad fod yr amser mae cleifion yn ei dreulio yn yr ysbyty yn lleihau, ond a oes unrhyw dystiolaeth bod ansawdd y gwasanaeth mae'r cleifion hynny yn ei dderbyn wedi dioddef o achos hynny? A oes unrhyw fath o fesur ynglŷn ag os yw'r cleifion hynny yn mynd yn ôl i'r ysbyty yn fwy aml lle mae'r amser roeddynt wedi ei

**Aled Roberts:** I want to refer to part 2 of the report, which mentions efficiency indicators. There is talk in the report that the time that patients spend in hospitals is reducing, but is there any evidence that the quality of the service that those patients receive has suffered as a result of that? Is there any sort of measure in relation to whether those patients return to hospital more often when the time that they spent in hospital originally was shorter?

dreulio'n wreiddiol yn yr ysbyty yn llai?

[63] **Mr Jeffs:** The short answer is that we did not look at that. What we focused on were the tier 1 measures, priorities and some targets that the NHS has, so we did not look around them. This is a very high-level overview, I guess. That is, potentially, the risk, but we have not picked that up anywhere, that shorter treatment potentially results in lower quality care. We have no evidence of that whatsoever. But, as I said, that may be because we have not looked in that area.

[64] **Aled Roberts:** Do you know whether the health boards compile that information or look at that? The suggestion is that reducing the level of stay in a hospital is more efficient, but if that leads to repeat admissions, clearly, it is not half as efficient as is made out if it is just looked at as a tier 1 measure.

[65] **Mr Norman:** I know that readmission rates are measured across the NHS, but as Mark said, that does not feature in the tier 1 targets. From what I have seen, LHBs and trusts would be looking at that information, and if they saw an increase or spike in the trends, they would look into the background to that and take appropriate action. However, as Mark said, we do not have any evidence that that has caused problems.

[66] **Mr Jeffs:** It may be worth thinking back to very early work that what was then the National Audit Office Wales did on waiting times. That identified a lot of issues with the length of stay around very inefficient processes—people were being kept in an extra day to wait for the doctor to come around and then an extra day again for somebody to come around and sign off the form for discharge. We have not looked into the detail, and this is probably something that we will look at with the waiting times report, but my expectation would be that a lot of the reduction is to do with a much greater focus on arranging some of those process issues that kept people in hospital an extra one, two or, potentially, three days, waiting for boxes to be ticked before they could leave, which would not necessarily have an impact on the quality of care and their likeliness to return. However, that is an issue that we will probably look into in the waiting times report.

[67] **Aled Roberts:** However, there are still process issues, albeit that there is an increased use of day care et cetera. For example, if you are actually admitted on a Friday, the likelihood is that you will wait until the Monday to see someone, which is hardly an efficient use of a resource when that person sits in a ward for three days with nothing happening.

[68] **Mr Thomas:** As we referred to in the unscheduled care report, the impact of people arriving, particularly at weekends, means that they are sometimes confronted with a reduction in beds available.

[69] **Darren Millar:** Jenny, you wanted to come in on this.

[70] **Jenny Rathbone:** Yes, very quickly, on page 8, in paragraph 12, you say that you have got some concerns about possible under-reporting of health-related infections. I just wondered what your evidence was.

[71] **Darren Millar:** Jenny, that is a slightly different issue, is it not? Can we come back to that?

[72] **Jenny Rathbone:** It relates to the length of patient stay. If there is pressure to get people into beds—

[73] **Darren Millar:** Okay; it was quite naughty to bring that up, but go on.

[74] **Mr Thomas:** The prime evidence that we have on that is the Betsi Cadwaladr issue: the lack of declaration of Clostridium difficile and the extent to which that was reported up to the Welsh Government.

[75] **Mohammad Asghar:** Thank you, Huw, for this report. During the recess I have had more people coming through the door of my constituency office regarding health problems than anything else. So, I do not want to go into details, but I will give you one or two examples: doctors not seeing people and not giving medicines for flu. 'Go home and have a rest', that is their answer; they offer no medicine, not even paracetamol. Also, people have been put on trollies for three days. I met, during the recess, the chief executive of Gwent health board—a wonderful person—but the board is constrained by these savings. Everybody, I think, is in the same boat. I am not saying that they are cutting corners—they are doing the best possible job under the circumstances. You mentioned in your earlier report that there is a deficit of £200 million. Is that right?

[76] **Mr Thomas:** At present.

[77] **Mohammad Asghar:** Yes. So, basically, how can you justify that the health service is doing better if there is a deficit? Dentists are putting people on private. If you miss two appointments, you are totally out of the practice. If you go on a Friday afternoon, the doctors are there to write reports, not to meet the patients. The NHS has the biggest slice of our budget in Wales. It is 60-plus years old, and a great jewel in the crown, but if you think of it as a car, or a body, it needs changing, oiling, servicing and different parts. We need to move with the times, and I think that we are still staying with the old principles and throwing a lot of good money away through bad practice. Sharing the practice, where there is good practice, is paramount in this department where money can be saved, so that we do not just throw money at the bad areas.

[78] **Darren Millar:** Is there a question in this, Oscar?

[79] **Mohammad Asghar:** Yes, my question is: how can you save money while there is already a shortage of many other services in the health service?

[80] **Mr Thomas:** First of all, the £200 million figure is the one that the health boards themselves are declaring in terms of the deficit that they now see at the end of the year, after they have made their planned savings. So, it is something that the Welsh Government will need to address. Secondly, I have consistently said in my reports that the only way through this is not to continue, in a sense, with the sticking plaster of trying to save one year—it is actually about standing back and changing the health service to a more stable and sustainable model. But, that requires the investment of funds, particularly in year 1, and in the current age of austerity it is difficult. The hope I would have is that the Welsh Government can successfully use its year-end flexibility to make that investment and allow savings to take place in years 3 and onwards. But, that does require a very central focus and drive from the Welsh Government. The health boards can certainly share good practice, but this needs vision and to be driven through in terms of achieving that. So, that is the challenge, and I think that what you have identified, Oscar, is absolutely the case—that is people's experience of the NHS. I am reporting what they are saying. They are saying, 'We are still £200 million short; we need some extra funds this year'.

[81] **Mohammad Asghar:** Chair, just one—

[82] **Darren Millar:** We will come on to service reorganisation. Very briefly, Oscar, and then I want to bring Julie in.

[83] **Mohammad Asghar:** When you prepared the report, Huw, I am sure that you must

have met most of the chief executives and heard their concerns about the constraints on funding. The performance and funding indicators are different—you know, if the performance is not there, the indicators are different. How have you convinced them to save the money, given the limited resources?

[84] **Darren Millar:** With respect, Oscar, it is the Welsh Government that sets the budget, not Huw's office.

[85] **Mohammad Asghar:** But how can they perform? That is what I am saying: performance can be compromised when the funding is not there.

[86] **Darren Millar:** I think that it is clear from your report, auditor general, that it is a mixed picture, is it not? There have been efficiencies and some improvement in the quality of service in some areas, but there has been a serious deterioration in others.

[87] **Mr Thomas:** Yes.

[88] **Mr Jeffs:** I would add that the big bit there—and it comes back to a recommendation as well—on that deterioration, is the extent to which that has been a clear, managed prioritisation process. Has it been consciously decided that those areas that have slipped are less of a priority, or has it been more ad hoc? That is probably a question to put to the Welsh Government, but that is why we have made our recommendation, because it is part of the challenges—that is, things that are less of a priority and managing the consequences of that in a disciplined way, rather than having it slip by virtue of not being able to find the money.

[89] **Darren Millar:** With the priorities, some appear to have been the subject of greater focus than others, do they not? Julie is next, and then Jenny.

[90] **Julie Morgan:** Obviously, you have referred to the deterioration in emergency services and in elective surgery. What evidence do you have that they were deliberately planned, so to speak, to come in within budget?

[91] **Mr Thomas:** We have also heard evidence from Betsi Cadwaladr that that was something that it took into account in adjusting. The figures would seem to suggest that the decline that took place in 2012-13 in elective procedures is quite stark. There was a change. The other is that, as we have done the audit of individual bodies, we have found that that has been a factor that some have taken and worked on. I would not say that they decided early in the year to do it; I think that as the year end approached, they shifted in order to avoid breaking the year-end target. Again, this is something that the introduction of the end-year flexibility would help, because they would no longer be required to hit the nail right on 31 March.

[92] **Mr Jeffs:** One the big financial areas is the issue of the waiting times initiative. If you go back over time, historically, in order to sustain or meet waiting time targets, part of the way in which the NHS has virtually always done it has been to run a series of initiatives—mostly as additional activity paid at weekends to consultants. However, many health boards decided not to do that. So, if you need to deliver a certain number of operations within a year to meet targets and you cut out a lot of the capacity to do that, inevitably, that will have consequences, and you can see those decisions reflected in the board papers of individual LHBs, and some have been very open in the press as well, to say that part of the financial pressures means that waiting times will sometimes have to slip. So, there is clear evidence, particularly on the reduction of waiting times initiatives, that that has been a conscious decision, and that has had consequences.

[93] **Julie Morgan:** Did you pick up the consequences of a decision like that, for example,

on the general operation of the staff and how they felt about it? Did you pick up anything like that?

[94] **Mr Jeffs:** No, we did not. As I said, we are going to take a look at waiting times, so that may be something that we could—

[95] **Julie Morgan:** You could look at it in more detail, because it is a fairly fundamental decision to make, is it not? Obviously, that is the issue about the openness that you discussed earlier as well, in terms of making these sorts of decisions.

[96] **Mr Thomas:** As Mike said, when we look at the waiting times, I would be very surprised if we did not find a link between delays in elective procedures and increases in the waiting times. However, I do not want to prejudge what that particular study will show.

[97] **Darren Millar:** Sandy, you wanted to come in very briefly, and then it is Jenny's turn.

[98] **Sandy Mewies:** Mr Jeffs probably answered this, but when Julie Morgan asked the question about elective procedures and how they were used as a tool, I was going to ask: it was not just Betsi Cadwaladr; you did find evidence of this in other health boards, although it is not transparent, is it? That is the point: it is not used transparently as a tool, but you did certainly find it in other health boards.

[99] **Mr Thomas:** Yes.

09:45

[100] **Jenny Rathbone:** If everything is a priority, then nothing is a priority, and you quite rightly point out that there is a need to reduce the number of tier 1 priorities. However, publicly announcing that service x is no longer a high priority can cause a predictable reaction. How do you think the Government should be going about this, or how do you think health boards should be going about it?

[101] **Mr Thomas:** I have to start from the fact that the health service and the Government have to live within the budget that is available. It is, therefore, better that the public fully understands what are priorities and what are not priorities, while recognising, of course, that there will inevitably be cases where people will protest and say that something should be higher up the priority order. However, it is better that it is open and transparent and that there has been a debate about it than that it is somehow hidden and massaged.

[102] **Jenny Rathbone:** Given that there is so much publicity around hospital services, there is a real danger that we are not looking at primary healthcare services, which is where 90% of healthcare delivery happens. I am concerned to read that there are still opportunities to make savings on the costs of primary care prescribing without impacting on the quality of patient care. I would have thought that it was a no brainer to really drill down deep on that one. Why do you think that boards have not—

[103] **Mr Thomas:** I think that boards have drilled down, if you look at some of the figures from previous years. However, there is scope to do more. We are producing a report on medicines management, which will allow you to look at it in more detail. You are quite right: if you look at the other report that you will be considering shortly, on unscheduled care, you will see the relationship between primary and community care and the pressures that eventually end up at the hospital.

[104] **Jenny Rathbone:** So you think that they are pursuing this. If you announce that you

are going to be ruthlessly forcing everybody to generically prescribe, the public will not be—

[105] **Mr Thomas:** There has been emphasis on that over the years. It is just that I consider that the bill is still high and asking whether there is scope for reducing it sill further.

[106] **Darren Millar:** Of course, there might be questions to ask about the impact of universal free prescriptions on prescribing, and whether that is leading to additional waste. Is that something that is being looked at?

[107] **Mr Thomas:** Clearly, that will show in the figures that we are looking at.

[108] **Mike Hedges:** I will preface my remarks by saying that I believe in two-year budgeting, as annual budgeting is fraught with difficulties. The question that I really want to ask, however, if we are looking at three-year budgeting, is this: if a health board manages to underspend in year 1 and carries the money forward, is there not a danger that it will be punished in future years? To use an example, if Aneurin Bevan had shown a £25 million overspend, it would probably have been given £18 million to £20 million; it showed nothing, so it got £10 million. It was £8 million to £10 million worse off because it did not show that it was going to overspend. Do you see a danger of that? I am sure that Aled Roberts will ask the question the other way around, but is there a danger, with underspends being carried forward, of health boards being punished for it?

[109] **Mr Thomas:** I think that this goes back to the culture that has developed. I have certainly heard some saying 'Well, if we show that we're going to break even, we won't get any extra funds in the course of the year'. However, that requires the culture in that regard to be driven out—that you are not going to simply receive a bailout mid-year. There has to be a responsibility on the body to live within its budget. Secondly, it is also about the Welsh Government being absolutely transparent as to why it is giving extra money and giving the justification for that. So, it is not simply bailout funding.

[110] However, the real test of three-year flexibility will be the extent to which individual bodies take ownership not just of year 1 and breathe a sigh of relief—'Yes, we've managed, we've knocked some funds over to year 2'—but take ownership of the three-year cycle, so that the upfront expenditure is balanced by savings in year 3. That is why it is so important that other three-year plans are linked into that—workforce planning and so on all need to be part of the structure by which individual boards approach their funding.

[111] **Mr Jeffs:** That is also part of the thinking behind our first recommendation. Although it is specifically around developing a shared understanding of what potential contingency money there is, what is really behind that is understanding the budget across the NHS as a whole, so that you do not have different bits making assumptions about what other parts of the NHS are doing—whether local health boards are holding back, or not holding back, and that sort of sense of gaming. Then, what you get is a collective approach, in which everyone is honest and open about what the Welsh Government has in terms of flexibility, and about what is happening in the other parts as well.

[112] **Darren Millar:** Were you able to see this perverse incentive for them to be poor, or to be overly negative in terms of their financial forecasting, in order to try to attract funds?

[113] **Mr Thomas:** I do not think that we have seen that, in terms of proof, but what you pick up—as Mike was indicating—is that view.

[114] **Darren Millar:** I have a question on the three-year funding cycle. We have often heard the breakeven requirement referred to as the NHS having to land a jumbo jet on a postage stamp. However, if it simply has to land that jumbo jet every three years, it does not

make it any more difficult or easier, in many respects, does it?

[115] **Mr Thomas:** It is only easier if you have really good financial discipline and a good regime and, as I have said, that you are planning for three years. If your vision is still, 'Where are we this year?', there is the risk that, in year 3, you will be back to where you were before flexibility was introduced.

[116] **Aled Roberts:** Mae'r Llywodraeth, wrth gwrs, yn cyflwyno Bil yr wythnos nesaf a fydd yn galluogi byrddau iechyd i edrych ar gyfnod o dair blynedd. Credaf fod y rhan fwyaf ohonom, mewn egwyddor, o blaid y newid hwnnw, oherwydd y byddwn yn gweld mwy o hyblygrwydd. Fodd bynnag, un peth sy'n fy mhoeni i yw eich bod newydd sôn am yr angen i gael disgyblaeth ariannol. Un wers a gawsom ychydig cyn toriad yr haf oedd honno gan Fwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr, lle nad oedd disgyblaeth ariannol. Nid oedd cyllideb wedi ei derbyn gan y bwrdd erbyn diwedd y flwyddyn. Ym mis Hydref, roedd adrannau o fewn y bwrdd iechyd hwnnw yn dal heb gytuno eu cyllideb â'r bwrdd canolog. A fydd y Llywodraeth yn gosod rhyw fath o gyfundrefn gadarnach o ran y ddisgyblaeth ariannol hon? A fydd yn ofynnol i fyrddau iechyd bennu cyllideb erbyn diwedd blwyddyn ar gyfer y tair blynedd? Heb hynny, mae perygl y bydd y pris yn rhy uchel i'w dalu.

**Aled Roberts:** The Government is, of course, introducing a Bill next week that will allow health boards to look at a period of three years. I think that the majority of us are, in principle, in favour of that change, because there will be more flexibility. However, one thing that bothers me is that you have just mentioned the need for financial discipline. One lesson that we learned just before the summer recess was that of Betsi Cadwaladr University Local Health Board, where there was no financial discipline. The budget had not been accepted by the board by the end of the year. In October, some departments within that health board had still not agreed their budgets with the central board. Will the Government provide a more robust system in terms of this financial discipline? Will health boards be asked to agree a budget by the end of the year for the three years? Without that, there is a danger that the price will be too high to pay.

[117] **Mr Thomas:** Rwy'n credu y byddwn yn ateb y cwestiwn hwnnw drwy ddweud mai cyflwyno deddfwriaeth heb ganllawiau yw'r perygl. Rwy'n credu y bydd yn rhaid cael canllawiau cadarn gan y Llywodraeth, a disgyblaeth oddi fewn i'r byrddau iechyd, os ydych yn mynd i wneud llwyddiant o roi'r hyblygrwydd iddynt.

**Mr Thomas:** I think that I would answer that question by saying that the risk is introducing legislation without guidelines. I think that robust guidelines from the Government, and discipline within the health boards, will be required if you are going to make a success of providing flexibility to them.

[118] **Mohammad Asghar:** In your report, Huw, you mention that the department's explanations for the deterioration in planned and emergency services have focused heavily on external factors, such as a rising demand from older people, the prevalence of illness, the weather, and socioeconomic issues. How might the Welsh Government's understanding of the impact of certain issues, such as finance and a reduction in bed numbers, on achieving performance targets be improved?

[119] **Darren Millar:** We touched on some of these issues earlier, so if you could give us a brief response to that question.

[120] **Mr Jeffs:** That is obviously something that we will look at in the waiting times report, in particular. However, it is about getting a better understanding, and an open understanding, of the impact of the decisions that have been taken in terms of the waiting times initiatives, as well as issues around bed capacity. There are fewer and fewer beds each year, and, in part, historically, that has been offset by the issue around decreased length of

stay. Therefore, you create new capacity because people are staying less, but there is a limit to how far you can squeeze that down without it having an impact on elective activity. So, it is a better understanding of how those sorts of more financially driven elements feed into the mix, alongside some of these other external factors, to get a more holistic picture; I think that that is what we are saying would help the Welsh Government.

[121] **Jenny Rathbone:** You mentioned the inconsistency in budget assumptions by different health boards in forecasting cost pressures. Continuing healthcare is an interesting one. We have had reports elsewhere about how much that is contested and it ends up costing money anyway. How could we ensure that health boards are all using really robust methodology rather than thinking of a number and hoping it turns out right?

[122] **Mr Norman:** We have identified that there is an issue in the report. As we say in the report, we are seeing variability between what the Welsh Government is suggesting and what local health boards and trusts are suggesting. What happened for this financial year is that the directors of finance group went away and had a look at it. I think that that was a very good start. They certainly improved on consistency and that is something that will be built on in year 2. What we need to be careful of is that the Welsh Government does not come up with a direction saying, 'You must use these assumptions'. There will always be local circumstances for individual health bodies and different cost pressures. Continuing healthcare is a really good example where some LHBs have had increased expenditure and others have had decreased expenditure. There are always issues to do with local circumstance. As we say in the report, it is over to the Welsh Government to pull it all together, to look at it for consistency and then disseminate something back out to the service.

[123] **Jenny Rathbone:** So, in terms of the figures you published in 'Implementation of the National Framework for Continuing NHS Healthcare', the assumption is that it will next year go down considerably on what is predicted for this current financial year. Are those figures based on good evidence?

[124] **Mr Norman:** We have not gone into the detail of the evidence behind it. What we have done is highlight that there are a number of differences. I suggest, as I said earlier, that it is a good start. There is much more consistency with this information, but there is further to go. As you can see, the bottom line figures suggest that there are significant financial cost pressures across the NHS with which, when you look at it against the flat cash settlement that the service is receiving, there are issues year on year.

[125] **Mike Hedges:** From my experience, correct me if I am wrong, in the first quarter of each year, local health boards tend to overspend and then in the last quarter they tend to try to bring it all back. You have reported on this on a number of occasions and you have said:

[126] 'NHS bodies to profile technical accounting adjustments and central savings across the year.'

[127] That is what they should do, rather than do it at the end of the year. What have been the barriers to NHS bodies implementing your previous recommendations? What seems most perverse is that if you are making savings in your last quarter, and if they are continuous savings, you should do very well at the beginning of the next year because you will have four quarter benefits of one quarter savings. However, we all know that that is not the case.

[128] **Mr Norman:** From what we are seeing from the local work of each of the LHBs and NHS trusts, there are generally pockets of good practice, but there are issues around how cost improvement plans are arrived at. They are often arrived at quite late in the financial year, as you suggest. Sometimes, plans are not agreed until maybe three or four months into the year. There is then obviously a delay in staff actually being able to deliver those plans. So, there

does seem to be, as you quite rightly suggest, a drop off in the first half of the year and then the NHS generally is frantically trying to recover the financial position later in the year. As we say in the report, that cycle does not seem to have been broken. I think that it has probably got a bit better and hopefully the three-year planning horizon that Huw has mentioned will help, but, from what we have seen, it is something that is almost a cultural part of the NHS.

[129] **Mr Thomas:** I think that figure 10 on page 24 illustrates that.

[130] **Julie Morgan:** For 2013-14, you say that there will be a funding gap of £212 million.

[131] **Mr Thomas:** The latest figure we have had from the health boards is £200 million.

10.00

[132] **Julie Morgan:** Right. Looking at page 48, at the forecasts, obviously, if that has gone down already, further savings have obviously been identified. Do you see any potential for other savings to be identified?

[133] **Mr Thomas:** I think that we are into the same cycle as in previous years. Without extra funds provided to them, I doubt whether the boards can actually break even. They will probably adopt other short-term measures towards the end of the year. However, the cycle has to be broken. Let us go back to say that we think that the only way that it can be done is by actually allowing them a longer-term horizon in which to identify proper savings that are sustainable.

[134] **Darren Millar:** That brings us to the end of the questions from committee members, but I have just two questions to ask you before we close this part of the meeting. You make a reference in paragraph 1.4 to negligence claims, and this being a pressure that some of the health boards have to provide for. Could you give us some indication as to the size of those claims compared with previous years, whether there is an increasing trend here, whether it is a clear sort of indication, if you like, of dissatisfaction with services, or whether it is just a consequence of the problems, perhaps, that the financial situation has caused? Did you carry out any analysis of that?

[135] **Mr Norman:** We have not looked at it in detail. I think that what we would say, in terms of clinical negligence, is that cost has increased. I am not sure whether there is an exact figure.

[136] **Darren Millar:** There is not.

[137] **Mr Norman:** I cannot see it before me at the moment. I think that what we are seeing—and this has come up over the last number of years—is that there does seem to be an increase in cost. It is difficult to say what the reasons for that are, but it is either because there is more of a claims culture—and I think that there is a lot of evidence that suggests that people are looking to make some sort of financial gain if there has been a slip-up with the NHS—or the other angle is that there are more incidents within the NHS. I would not like to comment on the second point, but from what we are seeing, we are talking in terms of tens of millions of pounds going into clinical negligence across Wales. It must be an increasing drain on the NHS going forward.

[138] **Darren Millar:** There is a growing financial risk that the NHS needs to account for, clearly. I have one final question. At the outset of this particular briefing, auditor general, you referred to the opportunities that service change might bring in order to assist the NHS to achieve more sustainability with its finances. What evidence is there from the existing service change proposals that we have seen in different parts of Wales that costs will be reduced? The

plans that I have seen in north Wales, west Wales, and indeed for the south Wales programme to date, all demonstrate an increase in costs rather than a reduction.

[139] **Mr Thomas:** I think that I made the point that we need to actually look at the NHS provision in the wider sense of the delivery of the health service in Wales. That requires that there are interventions to prevent people from falling into the acute categories that, in a sense, we traditionally associate with NHS hospitals. It does mean investment in prevention, and investment in primary care and community care. The focus, I think, of too much of our discussion is purely on the hospital side of things. I recognise that there are problems there, but we are not going to achieve savings if that is the area that we concentrate upon.

[140] **Darren Millar:** But, auditor general, I am not asking you about the merits of focusing on issues other than hospital care; I am simply stating the fact that the service reorganisation proposals that have been coming from north Wales, west Wales and the south Wales programme all demonstrate increases in costs, in both the short and longer term, rather than a reduction in costs, which is what you seem to suggest that they needed to aim for through service change and reorganisation.

[141] **Mr Thomas:** When we get all of the responses in, it is important that we take stock of what they are going to cost. For north Wales, for example, I am conscious that, while we have seen the proposals for the community restructuring, we have not yet seen the proposals for the acute services restructuring. Both will need to be seen together. It is important, because unless we look at the totality of provision, and unless we recognise that perhaps we do need to specialise and improve the quality of care that people get, we will continue to spend money on maintaining buildings and services that, in a sense, are not as efficient.

[142] **Darren Millar:** Very briefly, Oscar, and then I want to draw this item to a close.

[143] **Mohammad Asghar:** Thank you very much, Chair. One area that you have to look at, Huw, is that when every patient registers with a doctor, that doctor gets nearly £66 per person per year. Basically, have you got any sort of record of when people move around? I think that that is the data that doctors do not have. They claim the money for people, even though they are not visiting surgeries and have moved away from there, and no such record is maintained. The second area is dentists. They made their own rules and even the chief executive of the NHS has no power to change those rules. Can you look into it, please?

[144] **Mr Thomas:** I will certainly consider those points.

[145] **Mike Hedges:** May I ask one question?

[146] **Darren Millar:** Go on, Mike, spit it out.

[147] **Mike Hedges:** [*Inaudible.*]—for health, see hospitals—that has always been the mantra, has it not? Is there not a role for public health and preventative action in reducing costs in the health service?

[148] **Mr Thomas:** That was the point that I was making earlier.

[149] **Darren Millar:** Okay, we are going to bring this item to a close. I just want to get an indication from Members, first of all, whether you want to undertake a piece of work on this or whether you simply want to note the report. Obviously, there is a piece of work going on in respect of the NHS finances Bill, which the Welsh Government is bringing forward, and we do not want to duplicate any work that the Finance Committee might be doing on that, but the auditor general indicated that there were areas that we might want to consider, such as the impact on the quality of the three-year planning process that the health boards might want to

bring forward as a result of the Bill; the potential for the frontloading of investment in order to deliver those three-year plans; why savings are difficult in some areas; why services have deteriorated in others; and the whole issue of service reforms that we touched on at the end of our session. Perhaps we could look at negligence claims as well and the risk that they might pose to the NHS in the future. Are Members content for us to undertake a short inquiry in respect of this, as we have done in previous years?

[150] **Julie Morgan:** I think that one of the most important points with all this, which has been referred to, is how you have the transparency in the debate about all these issues, because, as politicians, we will all shy away from saying, as Jenny said, 'We're not going to have any more. We're going to put one particular service on the back burner'? I do not know whether that is a debate to have in this committee or whether it is a debate that we could include.

[151] **Darren Millar:** I think that we could certainly put some questions to the Welsh Government as to whether it has determined what tier 1 priorities are, could we not, and whether that is something that is under review or not? Let us include it in the scope of our inquiry. If Members are content with that, then that is what we will do. I see that you are, thank you very much.

[152] Thank you, Huw, Mark and Geraint. We appreciated your help with that.

10:08

## Papurau i'w Nodi
## Papers to Note

[153] **Darren Millar:** We have a paper to note, which is the minutes of our meeting on 18 July. I take it that those are noted.

## Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
## Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

[154] **Darren Millar:** I move that

*the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).*

[155] Does any Member object? There are no objections, so we will move into private session.

*Derbyniwyd y cynnig.*
*Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 10:08*
*The public part of the meeting ended at 10:08*