Cynulliad Cenedlaethol Cymru
National Assembly for Wales

# Cofnod y Trafodion
# The Record of Proceedings

## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

## The Health, Social Care and Sport Committee

29/06/2017

Agenda'r Cyfarfod
Meeting Agenda

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| Dawn Bowden<br>Bywgraffiad\|Biography | Llafur<br>Labour |
| Jayne Bryant<br>Bywgraffiad\|Biography | Llafur<br>Labour |
| Angela Burns<br>Bywgraffiad\|Biography | Ceidwadwyr Cymreig<br>Welsh Conservatives |
| Caroline Jones<br>Bywgraffiad\|Biography | UKIP Cymru<br>UKIP Wales |
| Dai Lloyd<br>Bywgraffiad\|Biography | Plaid Cymru (Cadeirydd y Pwyllgor)<br>The Party of Wales (Committee Chair) |
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**Eraill yn bresennol**
**Others in attendance**

| | |
|---|---|
| Alan Brace | Cyfarwyddwr Cyllid, Iechyd, Llywodraeth Cymru<br>Finance Director, Health, Welsh Government |
| Rebecca Evans<br>Bywgraffiad\|Biography | Aelod Cynulliad, Llafur (Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol)<br>Assembly Member, Labour (The Minister for Social Services and Public Health) |
| Vaughan Gething<br>Bywgraffiad\|Biography | Aelod Cynulliad, Llafur (Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon)<br>Assembly Member, Labour (The Cabinet Secretary |

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| | for Health, Well-being and Sport) |
| Dr Andrew Goodall | Cyfarwyddwr Cyffredinol, Iechyd, Llywodraeth Cymru<br>Director General, Health, Welsh Government |
| Albert Heaney | Cyfarwyddwr, Iechyd Cymdeithasol ac Integreiddio, Llywodraeth Cymru<br>Director, Social Services and Integration, Welsh Government |

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

| | |
|---|---|
| Sarah Sargent | Dirprwy Glerc<br>Deputy Clerk |
| Sian Thomas | Clerc<br>Clerk |
| Dr Paul Worthington | Y Gwasanaeth Ymchwil<br>Research Service |

*Dechreuodd y cyfarfod am 09:45.*
*The meeting began at 09:45.*

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

[1] **Dai Lloyd:** Bore da i chi gyd a chroeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1, felly, a allaf i estyn croeso i'm cyd-Aelodau? Mae pawb yma felly nid oes unrhyw ymddiheuriadau. A allaf i bellach egluro bod y cyfarfod yma yn naturiol ddwyieithog? Gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r

**Dai Lloyd:** Good morning to you all and welcome to the latest meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. Under item 1 I'd like to welcome my fellow Members. Everyone is here so there are no apologies. Can I explain that obviously this meeting is bilingual? You can use headphones to hear simultaneous translation from Welsh to English on channel 1, or

Saesneg ar sianel 1, neu i glywed cyflwyniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i bellach atgoffa Aelodau i naill ai ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall, neu eu rhoi ar y dewis tawel, achos mae'n tueddu i amharu ar y system ddarlledu? A hefyd a allaf i hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu?

amplification in the original language on channel 2. I'd like to remind Members either to switch off their mobiles and any other electronic equipment or to switch them onto silent, because they can interfere with the broadcast system. I would like to inform people that they should follow the ushers if there is a fire alarm.

## Craffu ar Gyllideb Llywodraeth Cymru 2017-18—Sesiwn Graffu Ariannol Canol Blwyddyn—Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon a'r Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol

## Scrutiny of the Welsh Government Budget 2017-18—In-Year Financial Scrutiny—Cabinet Secretary for Health, Well-being and Sport and the Minister for Social Services and Public Health

[2] **Dai Lloyd:** Symud ymlaen nawr i eitem 2 a chraffu ar gyllideb Llywodraeth Cymru 2017-18—gwaith craffu ariannol yn ystod y flwyddyn. Mae hyn yn fater sy'n arloesol i bwyllgorau yn y Cynulliad hwn y tro hwn. Felly, i fynd ynglŷn â'r craffu yma, rydw i'n falch iawn o groesawu Vaughan Gething, Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon; a hefyd Rebecca Evans, Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol; Andrew Goodall, cyfarwyddwr cyffredinol iechyd; Alan Brace, cyfarwyddwr cyllid iechyd; a hefyd Albert Heaney, cyfarwyddwr gwasanaethau cymdeithasol ac integreiddio. Croeso i chi gyd. Rydym ni'n diolch am eich tystiolaeth ysgrifenedig ymlaen llaw

**Dai Lloyd:** Moving on to item 2, scrutiny of the Welsh Government budget for 2017-18. It is in-year financial scrutiny. This is an innovative approach for committees in this Assembly. So, regarding this scrutiny work, I am pleased to welcome Vaughan Gething, the Cabinet Secretary for Health, Well-being and Sport; Rebecca Evans, the Minister for Social Services and Public Health; Andrew Goodall, director general for health; Alan Brace, finance director for health; and also Albert Heaney, director for social services and integration. So, welcome to you all. We thank you for your written evidence and, as usual, we'll go straight into questioning. So, the first questions are from Caroline

ac, yn ôl ein harfer, fe awn ni'n syth i mewn i gwestiynau. Felly, mae'r cwestiynau cyntaf o dan ofal Caroline Jones.

Jones.

[3] **Caroline Jones:** Diolch, Chair. Good morning, everyone. I'd like to base my questions on the outcomes from the additional £240 million NHS investment. I'd like to say in my first question that there still seem to be mixed messages about how the additional funding for local health boards in 2017-18 will be used. Will it be used for levering service change or will it just go into meeting funding gaps and overspends? Regarding the overspends, if this happens constantly, is the baseline right to begin with? That's my first question.

[4] **The Cabinet Secretary for Health, Well-being and Sport (Vaughan Gething):** Thank you. I think there's more than one question in the first question—

[5] **Caroline Jones:** Sorry about that. [*Laughter*.]

[6] **Vaughan Gething:** —but I'll try and work through them because obviously these are big issues for the future of the service. It's worth reminding ourselves, when we think about the budget that we're talking about and the additional money, that this is based on the work that we had done previously by Nuffield Health and the Health Foundation. They told us that we needed about £200 million extra on a regular, annual basis to keep the wheels turning in the health service. They didn't say that was £200 million for significant service transformation or improvement. So, that's money to keep the service going, and that's on the basis that we continue to have year-on-year efficiencies made within the service, as the health service has done for a period of years.

[7] It was also on the basis that there would be continuing pay restraint, which I'm sure we'll talk about later on, but that's a real risk, as we've seen, in terms of the goodwill of staff and the ability to deliver pay restraint. I'm sure I'm not the only person here who would like to see pay restraint end for staff in the health and public service, but that's a choice to be made at a UK budgeting level, to allow us to do that. But there are those big risk factors. Also, let's not forget, because we're talking about health and social care, it pointed out that actually inflation in social care, which they hadn't addressed, was running at over 4 per cent, and that's a really big challenge

for us too.

[8] So, when you talk about the £240 million, that there's lots and lots of money in there to go out and say there's extra money to deliver service reform, the point I'd make about that also, which is a bit different to the money, is that lots of service reform we could and should deliver is not about saying, 'You must have more money to deliver service change', because sometimes you can deliver service change, improvement and efficiency, whether it's from a technical or allocative end—looking at Alan here, who'll no doubt tell me later on whether I've got this right—. You can do some of that by changing the way in which you run the service and the culture.

[9] That's why the prudent healthcare movement still really matters, because that's a way of driving more efficiencies through our service and genuine reform, and at the same time not surrendering our values as well. So, that's still about how we use the large sum of money we have, as well as the additional sums of money we have. So, service change: the drivers for that are partly about the health service inflation that is still there. And the £240 million that we're putting in—a bit more than that, actually, which I'll explain shortly—doesn't mean that the NHS is awash with money. There are still very real choices to be made, even in those health boards that have met the financial duty. I've already made the point about service change not being necessarily reliant always on money, and often it isn't the money that makes service change difficult, as all of us in this room know. It's us, as politicians, it's the public, and it's clinicians, who all need to buy into what service change looks like and the case for change not just being about money. The drivers for it aren't just money; they're also about demographic change, the demand that we know is coming to the service, and they're also about the need to change services on a quality basis as well. If we don't change some of our services and wait for them to be broken, we're actually saying that we're prepared to wait for people to suffer real clinical harm before we change the way in which services are run. Those are real and serious issues that I know the parliamentary review will look at in a number of different areas as well. So, that's part of it.

[10] On the point you make about health board overspend, we've been upfront from some time out about those boards we were worried about, and whether they'd meet their financial duty or overspend. We then confirmed—I think in the last scrutiny session—that we didn't think the four health boards would meet their duty, and they haven't. We've been upfront, and it won't be a surprise about the integrated medium-term plan statements as well, about

those—all the ones that we've approved and those that we haven't. So, I think we've been pretty transparent and upfront, and we've made a choice about what to do with this because we could have simply said that everything is balanced and no health board has overspent. We could have effectively hidden the overspends that exist in health boards. We made a choice to highlight and be upfront about those boards that are not living within their means, and the balance of money that we are retaining to cover the health service overall, and to be really clear about those boards that we do not think are managing their finances in a way that is sustainable, and where there is still a need to change. That is partly about the way in which they manage their finances, and not just about broader service reform.

[11] The £240 million we've got, you will have seen the additions that have been made, both in the way we've used that—. Some of that money's gone into inflationary pressures within the hospice service, but also primary care; £20 million has come in from the agreement we did with Plaid Cymru in the previous budget, going into mental health; and we put additional money into two health boards who can go on and do more on performance as a result. They're in a position where they can do that. So, we're allocating money to try and get gain where gain is possible, but not forgetting that the overwhelming case here is about how we use the budget overall to deliver the service change that we know is inevitable and necessary, not just because of money, not just because of the demand that will go into services, but also because there is a very real quality case to be made about improving services for the public.

[12] **Caroline Jones:** But are the targets set for the health boards realistic to achieve to begin with?

[13] **Vaughan Gething:** Yes, and I don't think it's about changing the baseline. There will always be a question and a conference to have at various points about how we allocate money on a formula basis and how we understand what need exists, balancing the needs, say, of rural healthcare, as opposed to delivering healthcare for significant areas of deprivation, and there are different arguments to be made. There will be no formula that keeps everyone happy because of the competing demands that exist, but in the work that we had done by both Nuffield and the Health Foundation, it did show that we are potentially in a position where our service is sustainable, and they did not think that was a case for colleagues in England. The risks of that are that if we don't see investment continuing to be made in public services, then that will give us a different answer. So, these next four or five

years are really important for what sort of health service we will have, both in terms of the reform that we think is a necessary thing to want to achieve in any event, but also where the money really does drive us in a different direction. Because whilst the health service isn't awash with money, compared to other parts of public service, we have done relatively well within this part of Government. There is extra resource, in real terms, going into the health service that is not going into other parts of public services. So, there is an even greater responsibility to deliver on a quality-led and demand-led reform that must take place, because other parts of public service are suffering in very real terms.

[14] **Caroline Jones:** Okay. Thank you. Also, the figures are slightly unclear because, in the submission, there's £110 million identified to meet inflationary costs. So, can we please have clarity about what is in this £110 million and what, of the £240 million increase, actually remains for the development of services?

[15] **Vaughan Gething:** I tried to point out that, actually, you know—

[16] **Caroline Jones:** I know you said that it's £200 million to keep it turning, anyway.

[17] **Vaughan Gething:** —the point about what is and isn't development of services, but the broad stuff about pay and inflationary pressures goes between primary care and secondary care. We made particular announcements, for example, like the £20 million going into primary care for inflationary pressures and £90 million going into the rest of the service. With the rest of the money, we've held back around £95 million to try and manage those pressures across the service because we know that there are four boards that are overspending, and there's still an expectation and a real drive to see an improvement in the first two months of this year, actually, in the expected position in the run rate to where they are now. That's partly about the steps that we've taken proactively about the way in which boards manage their money. It's about the direction and the conversations I have with chairs. It's also about the interaction that Andrew Goodall and Alan Brace have with chief execs and finance directors as well. So, we've seen a narrowing in the expected gap, but that £95 million is being retained centrally to try and manage those pressures, and, as I said, there's £15 million being released to Cwm Taf and to Aneurin Bevan to actually make more progress on improving performance and achievement. So, that's where the £240 million is used and is allocated, and, of course, I mentioned earlier

the £20 million of additional money that we agreed to go into the mental health ring fence in our budget agreed with Plaid Cymru.

[18] **Caroline Jones:** So, is the Welsh Government therefore satisfied with how well service transformation is being achieved in health and social care in terms of both the extent and pace of change? Is it delivering the change that is intended to drive the NHS forward?

[19] **Vaughan Gething:** Well, the short answer is 'no', because how could I ever be satisfied with the pace and the delivery of change? There's so much more to do. That's partly because the NHS has always had to reform and change through its history, but it's also because of where we started the series of questions about the very real drivers about demand—not just age, but public health as well—and the very real drivers over finances that will make choices, and we need to get ahead of those choices, but also the quality case for change and improvement as well. So, I said when I was appointed to this role that I wanted to see scale and pace in the way in which we deliver service reform and improvement, and it's the right challenge to give the service and the right expectation to set. The difficulty always is whether we're able to do that. So, there are good ideas that appear to deliver service transformation in one part of the service, but we still need to be more demanding in our expectation that they get delivered on a wider basis. Actually, that's within health boards, not just across and between health boards as well.

[20] For example, I was having conversations yesterday about improvements made in the way in which we deliver eye care in the west part of the Abertawe Bro Morgannwg health board, but, actually, they haven't been able to do that as successfully in the eastern part of the same health board. That's something about the nature of a really complex organisation that doesn't just spend lots of money; it's got so many different facets and organisations between secondary care and local and primary care that, actually, there's an understanding that delivering change is difficult. You can't just click your fingers and say, 'There's a ministerial lever to pull and everything will change'. Actually, if we don't have clarity in our expectations for change and reform that is based on quality, and understanding and anticipating the changes in demand that we know are coming through, at the point that there are real efficiency gains to be made that don't compromise our ethos, but should lead to a better use of the capacity that we have, then we're setting the wrong expectation.

[21] So, I wouldn't tell anyone that I am satisfied with the pace of change or the scale of change. We know there is more to do, and, actually, I think the parliamentary review that Members in this room will be well aware of, and the contact group we'll have more conversations about as well, is an important step forward in us trying to understand what the case for change is. So, not just, 'Listen to the Government', but an independent group saying, 'Here's the case for change. What does it look like? What do we think you need to do in the next five to 10 years?' and then the detail of some of those answers that we'll get challenged over, and not just challenges to the Government, but every politician in the room and beyond about: what do we really want? To answer this question of: how much money do we have, is it enough and, in any event, how do we make the best use of it? Because those demand drivers, and that quality case for change, aren't going to go away.

[22] **Caroline Jones:** So, could you give me one example of change that you think will be a good change and give me that example of where you will be satisfied with that change?

[23] **Vaughan Gething:** Well, I've already said in public before that we're looking at ways in which to change the way we deliver eye care. We've already had some change, for example, in the way in which we provide services in primary care—that's high-street optometrists, and the way they can do things that, previously, people would have been sent off to a hospital for. The way in which we have nurse injectors, and the way that, when wet age-related macular degeneration first started to be treated, actually you had to go into a theatre to do it. Now you can have nurses trained and, actually, mobile orthoptists trained to do that as well. That's a significant change and it means that it's more accessible and less expensive. But, actually, that's a service change that was expensive. It was an innovation that was expensive to deliver but really high value to the individual, and the ongoing work that I've already talked about in previous times, on changing our referral-to-treatment times, and the way in which we're looking at those measures, that could be really important in having a more clinically smart and useful way to have targets that make sense and drive the right clinical behaviour in that area.

10:00

[24] That's work that has to be done by the service, including clinicians, managers. It means there's IT that needs to change to help deliver that. It also means that we need to listen to the voice of the third sector and the

patients in delivering that change as well. I think that, over the next year, we'll see more work done on that, which I think will be a really important quality improvement, which should also mean we use our resources better as well.

[25] **Caroline Jones**: Thank you. Diolch, Chair.

[26] **Dai Lloyd**: Did you want a supplementary here, Angela?

[27] **Angela Burns**: No, I'm fine, thank you.

[28] **Dai Lloyd**: Full answers; you're satisfied. Excellent. Moving on—Jayne.

[29] **Jayne Bryant**: Thank you, Chair. Good morning. There are lots of different individual funding streams on top of the core allocation, such as the intermediate care fund, primary care money, services for older people. With this in mind, do you think this helps to drive the change that we need?

[30] **Vaughan Gething**: Yes. It's a funny thing about delivering change in the service, because you would have thought that, with an enormous budget of nearly £7 billion, you talk about the way in which the great majority of that money is used rather than the more marginal elements of money, which are, frankly—. The money that we've put into the integrated care fund is a large sum of money. Let's not pretend that the £50 million plus £10 million capital is a small sum of money, but, actually, when taken in with the whole budget, actually it's a smaller sum. I know Rebecca will talk about this, but those smaller sums of money make a really big difference in delivering change, and, in some ways, it's frustrating to think that, actually, the way in which you ask people to spend £10 million, for the sake of argument, can make a really big difference to improving performance, or the way that they work with other partners, rather than thinking about how you deploy your nearly £1 billion of a budget if you're one of our larger health boards. But that's the honest reality.

[31] The drivers for change that we have are clinical. Delivering clinical change in behaviour is the biggest thing that we can do, and that's also the most important thing in terms of persuading the public that there's a real case for change on a quality basis too. Because, as much as I like myself, I do accept, reluctantly, that the public are more likely to be persuaded by someone in the service rather than a politician in a smart suit saying there's a really big important case for change here. It's important to understand

that, and, actually, people in the service taking more ownership of the case for change. How those small sums of money get used is actually quite important in terms of delivering some of that change and changing behaviour, because, otherwise we have really big, blunt instruments.

[32] You can threaten to dismiss people, which happens on a regular basis in the English system. Sir Bruce Keogh pointed out in his leaving speech to the NHS Confed that the average tenancy of a chief exec in an NHS trust in England is 2.5 years, and I don't think that's healthy. So, that, in itself, is like your ultimate weapon, as it were, but it's a really blunt instrument, and that doesn't persuade lots of people in the service to do things differently. We can change the law, as we have done, and that's an important driver for change, but that isn't a quick driver for change either. The work that Rebecca's leading on delivering the Social Services and Well-being (Wales) Act 2014 and the partnerships, that takes time, but, actually, getting that right, with the change in culture and money that comes alongside it, gives a better prospect for seeing change delivered. If you look at—. I'll stop, because Rebecca will want to talk to you about examples of how we think, for example, the integrated care fund really has delivered change, but it's important to recognise that that sort of money makes a difference, but we still need to be more demanding about the main sum of money that goes into health and care services and the change we expect to see delivered with that in the main stream, and not just, if you like, the specific elements of funding we provide as well.

[33] **Dai Lloyd**: Minister.

[34] **The Minister for Social Services and Public Health (Rebecca Evans)**: Good morning, Chair and committee. Yes, I think the intermediate care fund, or the rebranded now as integrated care fund is, as Vaughan was saying, not just about the amount of money that we put in. Actually, it's about the structures that we put in around it, to ensure that the money is spent in a truly integrated way. So, our regional partnership boards have been up and running for over a year now, and I am pleased with the progress that they're making. They had a statutory obligation to provide us with population needs assessments. They've all done that. They're available now on the Welsh Government's website for people to look at. But we've also gone a step further and asked Social Care Wales to use those plans—to use those assessments, I should say—to provide us with a Wales-wide assessment of need as well. This is the first time that we'll have this kind of understanding of what the needs are locally, and specifically, really, for those groups of

people for whom we've asked the regional partnership boards to focus on as a priority—so, older people with complex needs and long-term conditions, including dementia, people with learning disabilities, children with complex needs due to disability or illness and now for the first time this year as well, carers.

[35] So, the next step for the regional partnership boards will be to use the assessments that they've carried out to develop plans to meet those needs that they've identified. This is the first time that we've ever really seen health and social care working together in such an integrated way, but also alongside housing and the third sector, and involving service users themselves, and carers, and so on. So, although the sum of money is £60 million, actually it is really driving change in the way that services are delivered, and we're seeing health and social services now coming together to integrate beyond, so, using their core funding beyond the ICF moneys as well. And, from April of next year, of course, we have the requirement that regional partnership boards—so, health and social care—jointly commission placements for adult social care as well. That's going to really transform the way in which we commission those places. At the moment, it's done 22 times by 22 local authorities but, in future, jointly seven times on that regional partnership board basis, and I think that that will make a big change in the commissioning arrangements that we have. So, we'll be commissioning for quality rather than commissioning on price. We've got work starting just this week, actually, looking at the future of fee levels in Wales as well, and I'm happy to update the committee in due course when that comes to some kind of conclusion.

[36] **Dai Lloyd:** On this point, Lynne.

[37] **Lynne Neagle:** It was just on what Rebecca had said, really, about the various strands of this work, which includes children with complex needs and disabilities. As you know, I was very concerned about what happened with the family fund in Wales. I wondered whether you could say a bit more about how you see that strand actually working to deliver for families with disabled children.

[38] **Rebecca Evans:** The population needs assessments that the regional partnership boards have completed look strongly at the needs of children and their families as well. So, there's a statutory duty now on local authorities to plan to meet those needs that they've identified, and I think that is really strong in terms of giving that statutory footing on which needs

are identified as well.

[39] Beyond that, of course, you'll be aware of the additional funding that we've announced for children on the edge of care and children in care—the additional £8 million of funding through the consequential funding announced recently. We know that, often, children in care also have disabilities or are also disabled and have multiple needs, so I can happily talk further about what we would expect to see from that additional money as well. I don't know if Albert wanted to add anything.

[40] **Dai Lloyd**: It's a budget scrutiny session but, yes, Albert.

[41] **Mr Heaney**: I think the only thing I'd add—thank you, Minister, and thank you, committee—is also that, out of the £20 million consequential funding that's been announced recently, there is £3 million for carers and respite. And it's really important for, certainly, families and children with disabilities and complex needs that the family structure around respite gives them that support as well.

[42] **Dai Lloyd**: Okay. Jayne.

[43] **Jayne Bryant**: Thank you, Chair. You touched on the importance of integration, and, following on from that, there is a significant range of bodies charged with spending these moneys—LHBs, clusters and, as you've said, the regional partnership boards. How can you be assured that this allows the bodies to really plan coherently and deliver the major improvement in service change that's needed?

[44] **Vaughan Gething**: As ever, it's not straightforward. We expect health boards to plan jointly with health board partners to engage in the third sector, but we set up clusters, for example, because we recognise that, actually, the cluster group and the cluster level of that population size is the right sort of size to plan for that population, to understand the local health needs of the population that those practices and partners are serving, and then to decide what they think will make a big difference to improving their healthcare outcomes and delivering against their needs. So, I don't wish to pretend there is a one-size-fits-all approach, but we do know, actually, that improving our planning function within health boards centrally is part of what we need to do.

[45] We were just talking earlier about the fact that four of our boards that

have not met their financial duty are in a heightened status of escalation. That demonstrates there's still more work we need to do about planning and delivering our whole system. And it's part of what the Organisation for Economic Co-operation and Development said—they didn't disagree with the structure in which we deliver this in general terms, but there were some questions about being clear about the governance within that. So, actually, it's a challenge of moving into a position where you don't just talk about Powys, Aneurin Bevan and Cwm Taf as well-run, well-performing health boards, but, actually, you have more health boards in that category as well. So, this next year to 18 months will be really important in doing that at a health board level, and then understanding how we join up local planning in cluster levels, and, actually, some local authorities have moved themselves to plan on the same basis. So, you can actually see neighbourhood planning taking place in local authorities on the same footprint as our primary care clusters, to try and aid some of that service integration and understand the needs of those larger community groups. So, there's something about understanding local health board and then cross-regional planning as well. That's why health boards have grouped themselves together—west Wales, ABM, and Hywel Dda having joint planning meetings. In south-east Wales, Cwm Taf, Aneurin Bevan, and Cardiff and the Vale are having joint planning meetings now as well, because they understand that patient flows across their health board areas are not neatly defined by health board boundaries as well.

[46] And, so, there are the different tiers of planning, and there's no pretence that there will be a simple and easy way and one way to plan a service, one way to deliver it, and everyone can buy into that. It is about understanding the complexity, about how we make it as easy as possible, and the clarity in expectation and accountability for delivering against outcomes. But, within that, you have to have space for innovation, because, otherwise, you choke all that off, and that, in itself, isn't good for health outcomes, or, indeed, understanding how to appropriately meet healthcare needs.

[47] **Dai Lloyd:** Andrew.

[48] **Dr Goodall:** And, Chair, just to comment that I think it's important to really try and bring everything back to the three-year plans, so the integrated medium-term plans, although, of course, we've got direct monitoring in place to make sure that these very symbolic areas can have an impact—areas like clusters, for example. We do introduce planning guidance. We are very

clear, and, actually, a lot of our contact that we have, in terms of the conversations that take place with the NHS, are very much looking at the broader spends and making sure that all of these tie back to the strategic plans of the individual organisations. And that's why there's such a lot of focus around approval or non-approval of these plans and the monitoring arrangements that we've put in place.

[49] **Dai Lloyd:** Okay. Moving on, Jayne.

[50] **Jayne Bryant:** Thank you. Just looking at the money invested to help with winter pressures this year, what is your assessment of how effective that's been?

[51] **Vaughan Gething:** I think we can be broadly satisfied with where we got, both in unscheduled care, we didn't see a—. We didn't see our system collapse in the winter. That might sound like a low bar of achievement, but, actually, we had real worries coming into the winter, as in every winter, about the ability of the system to deal with the rising nature of demand, not the numbers, but the numbers of very old, very sick people who come into our hospitals and then move around our health and care system. But that doesn't mean to say that our staff and our services weren't extremely busy. I went into a number of A&E units, but also into primary care as well through the winter, and there's very real pressure that our staff feel. So, let's not try and be glib about the fact that the system was okay because the numbers weren't as bad as we thought they might be. That isn't, I think, a particularly helpful way to look at it from an unscheduled care point of view. There's still more to do in understanding not just how we use the money, but how we understand what our system could and should do to improve unscheduled care throughout the year as well. And we've seen some improvements in that—the numbers of people going into hospital as unplanned emergency admissions. In chronic care conditions, our management of those conditions has improved, and that's really significant, because those people often end up staying for longer as well if they do get admitted.

[52] But it isn't just about the unscheduled care part of the winter planning, and the money to go in. We also wanted to make sure that we didn't see a significant dip in elective care as well, in planned care. And, in most health boards, we saw them meet the plans that they delivered, to continue to deliver an improvement. That's why we ended the last financial year in a better position on planned care than the year before—real gains made in referral-to-treatment time, real gains made in reducing the backlog

we have in longer waiters, with bumps in different parts of the service. The one board where we took money back was ABM, because they'd signed up to a plan and hadn't delivered it. So, we took money back. I think that's really important, in terms of the discipline we need to have in the system, because, if, otherwise, we say, 'Here's money that goes out to health boards for a purpose on the basis of plans they've submitted to deliver improvement', and we then say, 'Try your best, but don't worry, you can keep the money even if you don't do it', well, that's a really poor message, and we won't deliver the sort of discipline and approach that we need within our whole system.

[53] I think that's important in terms of behaviour as well at a senior leadership level. They need to understand that, when you sign up to something and you then get money on the basis of that, you're then expected to deliver against that as well. And if we don't have that clawback operating within the system, then I think that means that, otherwise, we compromise our ability to deliver improvement that all of us would want to see.

[54] **Dai Lloyd:** Okay. Rhun's got a question on this point.

[55] **Rhun ap Iorwerth:** Just to pick up on that, I would argue that orthopaedic elective surgery, for example, did collapse, certainly in the western region of Betsi Cadwaladr over the winter, with wards closed for elective surgery between December and April/May. How do you see that in the context of the budget that you laid for them, which helped them perhaps to deal with the patients who came in because it was winter, but helped nothing at all when it came to elective surgery?

10:15

[56] **Vaughan Gething:** No, 'helped nothing at all', I don't think that's a fair reflection on what actually happened, because, if you look at elective activity that continued through the winter, elective activity did continue. There's something also about commissioning that activity as well to allow you—because, in every winter, you plan to reduce areas of elective activity because you know you'll have more capacity taken up by unscheduled care, by those admissions that come in. That's not a surprise; it's not a secret that that happens. The challenge we have in terms of north Wales, and you'll have seen that they've had an orthopaedic plan delivered to their board, because they recognise that the way in which they currently use their resources isn't

optimal. They recognise they don't deliver the sort of efficiencies they need to against the demand they have coming in. I know we've run through this in the Chamber before, but, actually, Betsi Cadwaladr health board now perform significantly more orthopaedic procedures than they did five years ago. The challenge is that demand has run ahead of that significantly. In some areas, in particular long waiters, we've seen those rise to a level that, clearly, isn't acceptable. So, they have to plan to be able to deliver both the day-case activity—the stuff that we wouldn't have done 10 years ago—but also to understand how they deal with those long waiters as well. What the balance is in those areas where they commission activity on a regular basis, for example in Gobowen—people go there regularly for certain forms of their surgery. We need to understand what we will continue to commission on a regular basis outside of NHS Wales, and what we then do to be more effective and efficient with the resources we have within the service as well. And, for north Wales, that's an issue for—. And, for Powys, for example, as well, where they commission different forms of activity. There's got to be some honesty in the understanding about how you plan to manage winter in an honest way that reflects the reality that there will be more unscheduled care pressure coming in, and at the same time making sure that we don't see a complete stop in elective activity so that no-one gets to have those procedures undertaken.

[57] **Dai Lloyd**: Okay. Minister, briefly, because we've got to move on.

[58] **Rebecca Evans**: Yes, I just wanted to say something quickly about delayed transfers of care because, although they are a feature year-round, actually, they are a particular feature during the winter months. But delayed transfers of care in the first four months of this year we actually managed to keep under 400 for the first four months, and that's unprecedented. Delayed transfers of care at the moment are 12 per cent down on the same time last year. Actually, in the year to date, they're 21 per cent down on the equivalent period last year. I do think that's a significant achievement when we do see increasing demand due to an ageing population. I'm sure that we can attribute this to the work of the integrated care fund, which puts a lot of work into preventing people from going into hospital in the first place, but then also facilitating a quick release from hospital as well.

[59] **Dai Lloyd**: Grêt. A'r cwestiynau nesaf o dan law Angela Burns.

**Dai Lloyd**: Great. The next questions are from Angela Burns.

[60] **Angela Burns**: Thank you. Good morning. The questions I'd like to

pose actually pick up slightly on Caroline's about the IMTPs and the budget deficits and so on, but can I first of all clarify the three-year rolling forecast, which was introduced in 2014, which is obviously a really sensible methodology going forward for any large organisation of this kind of scale and complexity? Of course, in theory, that enables a health board to continually push its deficit forward and forward and forward and forward. So, when you say that you're judging them on a three-year, rolling forecast, at what point might you turn around and say, 'You've now got to catch up with that particular deficit', or is the intention that it gives them that flexibility to constantly flex for the rolling three years their particular financial situation?

[61] **Vaughan Gething**: Well, it allows flexibility, but you'll have seen in the settlements that are made whether people have met their duty or not. The flexibility comes from the point you make an assessment: 'Have you met your duty over these three years, "yes" or "no"?' And we know that there are boards that have not. Again, we've been completely upfront about that. When the Wales Audit Office published their report, we issued a statement on the same day, confirming that that's the position. Again, in the previous committee, I indicated that I didn't expect those boards to meet the duty. So, the flexibility—you see that flexibility in those health boards that have managed it successfully. So, it's understanding are there any additional pressures that are unique to those organisations, or is it really about how we improve what those organisations do in planning and delivering their services, and what do they need to do with partners, including other health boards, other statutory partners, and partners outside the statutory sector, to understand how they deliver that service in a way that is financially sustainable and sustainable from a service point of view as well. We've had some work done already on the four boards in a heightened status of escalation.

[62] So, we've had a governance review to look at the way in which they run and deliver their organisations and I'm looking forward to receiving those reports over the summer. Obviously, we'll update Members on the messages of those, because I think it is really important to understand, three years in, where are we, what are the positions of those boards that we don't think are—in fact, the Wales Audit Office have confirmed are not—living within the more flexible duty that's been provided, and, then, how do we ensure that, both within this year and the next year, we see a real improvement in those organisations as well rather than simply saying, 'These organisations haven't lived within their means', and then just move on? That would be the wrong response, because, ultimately, there are huge amounts

of money that are spent. As I said earlier, that money, the additional money going into health, comes at a real cost to other public services as well.

[63] **Angela Burns**: But this is the point that I'm trying to drive at, because what I'm interested to try and understand is, particularly when you look at Betsi Cadwaladr University and Hywel Dda health board, they have a consistent shortfall, so, what I am wondering is: does there actually need to be some fundamental recalibration of their baseline because there is an inherent backlog from way before? What is it about those two health boards in particular that gives them a—? Is there anything about those two health boards in particular that gives them a unique set of problems? I know, when I've talked to those health boards in the past, there is a lot of argument over rurality and the difficulty of providing healthcare in a very rural area. And, of course, you can argue that Powys is a very rural health area, but it doesn't have expensive hospitals up and down the length and breadth of Powys.

[64] So, Betsi and Hywel Dda do have that geography that plays against them. Rurality can be counted as a form of deprivation, but I'm not sure if there's any weighting. I just wondered if you'd give us some clarification of whether there is any weighting, when you're giving out money to health boards, for rurality. My understanding at present is that perhaps there is not. Just back to that comment that rurality is a form of deprivation—and I understand why you would give more weighting to areas of high deprivation, but it cuts the other way as well. Because this rump of overspend is consistent and I think, in any organisation, when you see that permanently set there, you've got to question that basic principle behind it and see if there needs to be that recalibration.

[65] **Vaughan Gething**: I'll make some brief comments and ask either Andrew or Alan to come and talk about the zero-based budget exercise that we're having done in Hywel Dda. Again, we've had discussions—. I know that Plaid Cymru are particularly interested in this as well; it came from conversations that we've had. But we think that won't just be useful for understanding what Hywel Dda's real base costs are, but also there'll be real value for other health boards as well to look at some of the methodology that's gone into that. But, also, to comment about the formula, because, actually, this has been a long-running concern, we're using what we think is the best, up-to-date formula that we have. We've got Townsend about how we understand the additional shares, but, actually, it is very easy to say, 'We are special and we are different', and every health board has a version of this, every health board has a version of 'treat me fairly'. If you talk to Cardiff

and Vale, they've got population growth that other health boards don't have to the same extent.

[66] **Angela Burns:** Yes, absolutely; I recognise that.

[67] **Vaughan Gething:** So, it's about matching and understanding what the different levels of need are and, actually, I think we should all have a healthy dose of scepticism about health boards that don't currently live within their means, about what the real scale of that is. Does it really account for a real answer? If it does, does it explain everything about the overspend that they currently have? And, actually, Betsi Cadwaladr, the chief executive there says that he thinks that, really, they have enough money within their system. It's about how effectively and efficiently they get to use it. But I do think that it will be useful to talk not just about the formula, but also the zero-based exercise, because I think that will be really useful to actually flesh out what we really think—not just what we think, but an independent view on what the additional costs are of running that system in that part of Wales and what else that tells us about the opportunities for improvement within that in any event.

[68] **Angela Burns:** Before you come in, can I just say that I totally accept that point and that's why I asked the question? Because, sometimes, you can have, in an institution, a legacy problem that you don't actually have the margin to deal with and get out of the way. And you know that, once you've dealt with that legacy problem, you can move forward and it's going to be a much clearer passage, going forward. But if you've never had enough of that fat to deal with those legacy problems then it's very hard, and that's why I wonder if we need—. You know, is there—. Because it's always these two that have this major problem consistently—if there's either a recalibration of a baseline or that pump-priming to get rid of or enable the management of that legacy problem so you then can move forward. Because I accept your point that on a revenue basis, year in, year out, there should be enough fat within health boards to run their organisations, but you're still not going to run it at a profit if you've always set out in the deficit, because you'll just keep that going. I mean, that's just—

[69] **Dai Lloyd:** Okay, and before you answer, sorry, Lynne's got a point as well.

[70] **Lynne Neagle:** It's a very interesting discussion, isn't it, and I certainly welcome what you've said about having a healthy dose of scepticism towards

health boards that consistently overspend, and I'm in the opposite position, because Gwent consistently—in fact, there's a small surplus? And under the Townsend formula, which has never been properly fully implemented, Gwent would have got a great deal more money, so the counter-argument is that Gwent isn't getting enough money to recognise that deprivation. So, I'd be grateful if you could respond to that point in your answer, really, and whether there is actually any intention to go further with the proper implementation of anything approaching resembling Townsend.

[71] **Vaughan Gething:** Well, when we allocate new money, we do it on a Townsend-share basis, so the new sums are going along that Townsend-share basis. None of this is easy, as this debate between different Members encapsulates, and why would we expect it to be any different? There is a real argument about how we allocate resources across the country and the relative level of need, and understanding what that need is. The zero-based exercise in Hywel Dda, I think, will be helpful for us to understand what that looks like, but equally it reinforces the points about reforming our service. Because, actually, if you currently run the model you've currently got and you know you can't live within your means for that, you should actually ask yourself, 'Well, is that the right model of care to be providing?' Some of that is about needing to pay over the odds to get staff in to keep models of care going, and that in itself is difficult, and some of that is also whether it's the right model even if you've got the staff there anyway. All those different questions need to be run and to be asked properly, sceptically, to understand how we then get to a position where we have the right resource going into organisations that are committed to actually using that money in a different way to deliver the service that we always want to see in every single part of Wales. But I do think it'll be really important to understand what we get for that. What do we think is the real cost for rural healthcare systems—do we need to reflect that in the way we provide the budget? And then does that explain the whole part of the gap?

[72] But, actually, we've already made some provision to recognise the current reality of where health boards are. You'll remember that last year I announced that we would be holding back a sum to try and understand where Hywel Dda and Betsi were to provide some of that support. And that's part of the recognition that, actually, we're not just saying, 'Get on with it—it's your problem', but, actually, there's got to be something real about what is a real basis for moving forward and saying, 'What is the sum of money that's required here?' and what we then expect health boards to do and to deliver, and to reflect and remember that the two health boards that live

within their means, that are large health boards with secondary care provision, actually cover a significant chunk of the most deprived parts of Wales. So, there is something about understanding how those health boards have been successful. And that's part of our challenging the system, about making sure that we transfer that successful leadership and understanding across our whole system.

[73] **Dai Lloyd:** The science, Alan? [*Laughter.*]

[74] **Mr Brace:** I think generally when we're looking at resources, I think we're looking at models of service and then how people are staffing those models and what that looks like on the financial side. And I probably would separate out Betsi from Hywel Dda when we look at that analysis, because under all of the funding formulas that we've used in Wales, north Wales has always been the best funded area within Wales, and that remains true under the current funding formula. If you look at the last seven years, in the first four years out of seven, Betsi Cadwaladr broke even; it's only in the last three years that they've hit difficulties. So, there is something in understanding now around what changes they need to make in their service models—can they appropriately staff it and can they do that within their available resources? And that's the work that we're doing with them.

[75] I think Hywel Dda is different. I think they've consistently not delivered a break-even position over the last seven years, and that's why we've commissioned a review. At the moment, the review is looking at the population and the demographics, it's looking at rurality and remoteness, it's looking at the scale issues, about trying to run perhaps smaller hospital facilities over a broader geographic patch, but it's also looking at efficiency opportunities as well—even within that configuration, are there known, agreed and measurable efficiency opportunities that the organisation could still go at? I guess when we get that report, it'll then give us a picture about what may need to be done on the resource side, but also what the organisation will need to do to drive greater efficiency and productivity within the model they've got until any changes could be made to that model.

10:30

[76] **Dai Lloyd:** Okay. And Julie—sorry, Julie's got a question.

[77] **Julie Morgan:** I welcome the way that you're approaching this, and you mentioned Cardiff and the Vale, and you mentioned the fact about the

increased population. I think there has been a long-standing issue about issues related to a big city—a capital city and the most deprived wards in Wales and the night-time economy and all those sorts of issues. There's been a long-standing issue related to that from people in the LHB. I just wondered whether you were taking that sort of issue into account when you were trying to look at what is needed, related to the models of care.

[78] **Vaughan Gething**: Yes, and it's part of what we expect the health board to be able to try and anticipate and manage. So, not just to say, 'We think we've got population growth other health board areas don't have, therefore that requires more money'—so what does that mean in practical terms? So, rather than just a bid for some more money, actually there should be an understanding or an attempt to understand what they think that is doing to their drivers for healthcare and how they anticipate managing that with their partners, as well as the conversation they have both with us as a Government but also with health board partners too, because this neatly again encapsulates the 'Treat Me Fairly' conversation.

[79] Gwent has significant areas of deprivation, as does Cwm Taf. Cardiff and Vale actually does as well—with my constituency hat on, I represent some of those areas—but it also has significant areas of affluence as well. Now, put all that in the mix, and you can get those versions in every other health board—it's what makes them different and unique and special. But, ultimately, there is a block of money that we have to allocate to the health service, and we will never get to a position where everyone is completely happy.

[80] The Townsend share is being used to allocate for the additional sums of money that go into the service. If we wanted to undo everything, we think we'd probably have too much flux within our system. But new money going in goes on a Townsend-share basis. So, those sums of money that are going into health boards now are going on a Townsend-share basis—the additional sums of money we're investing year on year.

[81] But I expect each health board to look critically at what it is doing and why, and this goes back into the population needs analysis and understanding as well, and how they plan to meet those. If there is a case about the different services they run, then there needs to be a conversation across the service, not just a bid into Government for more money. Because, as all of you know, as we're doing budget scrutiny, the NHS are doing better than other parts of public services with money coming in, but it comes at a

very real cost and it does not mean that that financial pressure disappears in other organisations. So, it's a point we take seriously in the conversation with Cardiff and Vale, but we'll need to see some more granularity on what that really means and how we then understand. Actually, the governance review I think will help to flesh some of this out as well. So, as I say, I think those reviews will be important not just for organisations in a heightened state of escalation, but across our system as well, even those relatively well-performing health boards at the moment. Equally, I think there'll be interesting learning across the system from the exercise in Hywel Dda about the zero-based budgeting exercise as well, to understand how you can assess the differing needs in that population and what that really means to expenditure and where you should start from. In all of this, though—the unavoidable part of this is that austerity is not ending any time soon. These challenges will get more acute, not easier.

[82] **Dai Lloyd**: Indeed, and we've been discussing Townsend here since 1999. Lynne and I will remember that—we were both considerably younger in those days—[*Laughter.*]—but the issues remain. Angela, do you want to mop up your section?

[83] **Angela Burns**: Yes, may I just have a couple more questions, Chair?

[84] **Dai Lloyd**: Yes.

[85] **Angela Burns**: Thank you. You've already mentioned that you've clawed back money from ABM for winter pressures that they didn't spend, and you've clawed back money from Betsi Cadwaladr. Will you be asking the health boards that are currently in deficit, and which you've been supporting, to pay back that money as well? Is that your intention, or are you not—?

[86] **Vaughan Gething**: Earlier on, I tried to get some clarity about not pretending that health boards have lived within their means or have performed better than they have done. So, again, the money went in to organisations to deliver a certain outcome that they'd planned for and they said they could do. When they didn't, the money came back in. We'll cover off the money so people can pay their bills, but it was showing their year-end position about how far away they are from actually achieving break even or not. So, effectively, it goes into their overspend and, like I said, if you don't do that, then I just think you lose the financial discipline that is really important to actually have as part of our system, and that we do see takes place in other health board areas.

[87] So, this is about improving not just financial management from the health board's point of view, but actually the broader point about achievement and reform and how they drive better efficiency into their whole system. So, there are important questions here, but, yes, the money gets clawed back centrally but we effectively have to cover that off in any event, but it means that you're not artificially demonstrating a better level of financial performance within that health board.

[88] **Angela Burns:** Could you just give a quick comment, then, on whether you believe—particularly for Betsi and Hywel Dda—that, given their financial situation, they have had enough money, or they have enough money, within their yearly running cost to be able to effect some of the very important—particularly that you talked about earlier—quality changes and delivery changes that you want to see and you're charging the health service with delivering? If they haven't got money and they're constantly in debt, I just wonder how they're going to be able to make those changes that they need to make.

[89] **Vaughan Gething:** Some of that goes back into what the drivers for reform are and how you deliver it. I don't want to get too philosophical but, actually, there are some things where you understand that you need to change the way you run a service because you will actually save money but you can also deliver better outcomes—that doesn't necessarily cost you extra money. In some parts of service reform, you may need to spend money upfront, for example on capital spend, but that doesn't cover against their revenue costs—but you then deliver revenue savings, the way you change the way in which you run the service.

[90] I'll give an example that I've used before about ways in which we think we can deliver more efficiencies—outpatients. It's not just my view—it's pretty much across the service—that outpatients isn't an effective use of clinicians' time and financial resources in the way it's currently run and delivered. The challenge isn't all the clinicians saying, 'Well, this is outrageous. It's a waste of time and money'—because, actually, a lot of clinicians within the service are part of the challenge and the behavioural change that is required to make sure that people aren't needlessly sent back into the outpatients' system for a follow-up that doesn't need to be made. So, actually, there's efficiency there to be delivered that will make better use of clinicians' time, better use of your and my and every other patient's time. If we don't need to go to an outpatients' appointment—for the time it'll take

us to get there, to park or to get public transport there, to then have that five minutes of time with a clinician, when actually, you need not have attended in the first place—. So, that's really important because that's real money being spent in a way that isn't effective.

[91] It should not be a significant additional cost to deliver some of that greater efficiency. That's a good example where 'efficiency' isn't a dirty word that sounds like it's privatisation, but, actually, it's really important. It should mean you have more capacity to use that precious public resource to deliver a better service in a better way. It goes back to the eye care example as well. We've changed eye care already and there are greater changes to come, but that does mean that you are more likely to see a consultant, if you need to see a consultant, because of the change we've introduced about delivering parts of that service within primary care on a high-street basis as well. Our challenge is how we deliver more of that and at greater scale and at greater pace. So, we come back to these themes, and that shouldn't surprise people. I think we'll keep on coming back to those themes through the next year and more, and we'll wait to see what the parliamentary review tells us again as well. I expect there'll be a real challenge about not just the level of resource we have, but actually how we use that resource being perhaps the most important question in delivering the reform that is necessary.

[92] **Dai Lloyd:** Okay, Angela?

[93] **Angela Burns:** I was going to ask you, Cabinet Secretary, and also perhaps Mr Brace as well—you both mentioned the word 'efficiencies' quite a lot of times—how would you define 'efficiencies'? Many would argue that the easy-to-have fruit has already been taken. I just wondered if you could give us some feeling of it. I do take your outpatients point. StatsWales are very clear: April 2016-April 2017, the outpatients appointments have dropped by 10,000 appointments. And if you replicate that throughout the whole of the rest of the year, that's a significant number of outpatient appointments saved—although it would be interesting to see what effect that has back down the line within GP surgeries. If you could just give a little bit more of an indication of the kind of efficiency savings that you think that the NHS still has to offer.

[94] **Vaughan Gething:** I'll make one brief comment then I'll pass you to Alan, who I'm sure will want to give a technical analysis. The one point that I would make is that when people say all of the low-hanging fruit is gone, I am healthily sceptical about that again as well. Outpatients reform—you're

saying 10,000 fewer—well, actually there's more to go as well. These are areas where clinicians have signed up to, on a national level, saying there are things that we could do in the way we run and drive behaviour into the system. It isn't about the public demand coming in, it's a demand that is generated by healthcare professionals in the system and the way it's used. I don't mean to be unkindly critical—I'm saying that cultural and behavioural change is really important to what gets done. Sometimes, that cultural change is more difficult, but actually to say all the low-hanging fruit is gone, I have real scepticism about that.

[95] **Angela Burns**: So do I. Don't worry, we're on the same page.

[96] **Vaughan Gething**: But actually, the more difficult stuff is often in the more valuable areas, not just in terms of saving money but in terms of delivering real value.

[97] **Dai Lloyd**: Alan—fruit, hanging low or otherwise.

[98] **Mr Brace**: You should never ask a finance director if there's low-hanging fruit. But I think, if I just take it at a summary level—what we're trying to achieve across all of the health boards—and then, if needed, perhaps give some examples. So, I think there's two types of efficiency that we've got an opportunity to go at within Wales. One is the technical efficiency, which is: without changing anything, can you get more for the same input? Can you cut your inputs and maintain your outputs? So, the normal sort of stuff you'd see in any sector. The bigger prize, I think, is what is in the allocative efficiency, allocative value. So, that's in an integrated system: could we move money? I guess the Cabinet Secretary gave examples about where you could move money out of traditional hospital provision into more primary care provision, and that is allocatively effective, can drive better outcomes, but can use resource better. We probably concentrated too much on the technical efficiency. If you look at the work of the Health Foundation, the long-running trend across healthcare systems is that 1 per cent to 1.5 per cent is probably routinely available within the technical efficiency. If you look across Wales, that's variable. Some people have driven greater efficiency than others.

[99] So, what we've done is, chaired by Andrew, we've got a national efficiency and productivity group, and that's achieved a number of things. There is a national framework of efficiency and productivity measurement now that all boards are using as part of their plans. The challenge within

there for boards is to share and make sure that everybody is getting to a consistent level, so that we're not seeing this variability. The medical directors within this group are looking at clinical variation: where have we got variation in clinical practice that we can improve? The nurse directors are taking a lead on how we roster our nursing staff better using e-rostering tools. Through the national informatics service we're looking at the efficiencies that ICT could give us, and then lastly we've got a lot of work going in the traditional areas of medicines and procurement, but, again, just making sure everybody is stretching themselves in a consistent way. On the allocative side there's lots of work going on within individual boards. In Aneurin Bevan they've just moved—they almost will save £1 million by shifting the pattern of service from high-cost intervention around medicines into much more pulmonary rehabilitation and smoking cessation. So, for a £0.25 million investment, they will save £1 million just by redistributing money.

[100] We've also signed an all-Wales agreement with the International Consortium for Health Outcomes Measurement—ICHOM—which is an international movement to try and measure outcomes that matter to people as well as the more sort of technical, clinical outcomes, and put that together and then have a look at how international systems are doing. So, all boards at the moment are measuring lung cancer, where we know we've got opportunities to improve our outcomes, and they're probably either going to do one different set and share or they're all going to do heart failure and measure that. Then we'll be matching resources—financial and workforce resources—alongside that, again with an expectation to drive up allocative efficiency, but more importantly effectiveness, and drive better outcomes for the money that we invest. So, I guess that's a snapshot. Are there opportunities? Absolutely. I think there's always this argument. Just by way of an anecdote, when cost improvement programmes first came into the health service, they were set at 0.3 per cent and everybody said the end of the world was nigh. Then, when it went to 1 per cent, everybody said there would be savage cuts because we could never get here. So, we have, over the years, always said that these are really difficult things, and yet we've always achieved and we seem to be capable because health services adapt and change. So, there will always be opportunities, I think.

[101] **Dai Lloyd:** Okay. We need some more agility now, team, because time is pressing on. Angela, you've—.

[102] **Angela Burns:** I've just got one more question, which I won't ask now.

But if there's time at the end, I would like to ask about agency fees.

[103] **Dai Lloyd**: Excellent. Rhun.

[104] **Rhun ap Iorwerth**: Thank you. I think you'll find most of my questions have been asked but there are a few issues that I'd like to explore. I'm interested in investing to save and the capacity of the NHS in Wales to invest to save. It's about, as you say, efficiency of inputs balancing with effectiveness of output. If you look at the additional funding, the £240 million, £110 million of it for inflation—. If we look, perhaps, at similar overspends to what we have now, maybe £85 million going on that, and £20 million for mental health services after the budget deal, there's not much left, is there, for that investment to save and to increase and improve outputs. Is that a fair assessment?

10:45

[105] **Vaughan Gething**: It's part of the challenge we have in our system about the inability of the health boards to live within their means. It means that where you could use money to try and transform services, the ability to do so is being denuded by the inability to live within means. That's a very real frustration. No point pretending that, as Government Ministers, we don't feel that.

[106] **Rhun ap Iorwerth**: That's fair enough. So, in reality, is the additional funding, really, just going to—at best, and being realistic—allow you to maintain the balance between the efficiency savings, the input and the output? It's hard to see where you can steadily or dramatically, even, improve outputs, seeing that there isn't much space for investment.

[107] **Vaughan Gething**: Well, we need to think about outputs and outcomes, because we can deliver lots of outputs without changing outcomes too much. I think it goes back to, if you like, where we started this session and thinking about the money we have to keep the wheels turning, but what 'keeping the wheels turning' means, and the space that allows you—and should allow you—to still transform and change a service, because we are asking the service to do both those things. We want the service to keep going and to deliver acceptable levels of performance, and I know that, in this room, and in the Chamber, you will all ask me why we're not doing better on a whole range of measures, and that's the natural part of scrutiny that is there, but it's also about how we change the systems underneath those. If you think

about the example you gave earlier on concerns about orthopaedic performance in north Wales, well, actually, as well as saying, 'Look, we can find some money to try and make sure that your performance doesn't slip further', actually you've got to change the way that system works if you fundamentally want to do something different. It's the same on the bubble we have on diagnostics in south-east Wales. We need to be able to change the way that system works and whether that's investing in resource—whether it's staff resource or others—. Actually, if we don't change the way in which our systems are run and that part of reform that isn't always about big service change and moving things around between hospitals—actually there's an awful lot of service reform that is entirely necessary that needs to take place, but to do that you have to keep the wheels turning as well, because otherwise, you're essentially looking at what the health service will no longer do. Austerity means that we can ultimately end up getting there. I think that you'll see that in parts of England, actually, where they're having to have that really difficult conversation. So, these are high stakes that we are playing for. But, again, I think the review that we're having will help us to flesh out some of those choices as well.

[108] **Rhun ap Iorwerth:** Who or what is driving innovation Wales-wide? Because I can see that every health board should be looking at ways to innovate within their own health board areas, but we also need to be looking at ways of innovating nationally. Where do we look in budget lines to see the investment that is being made on improving the Welsh NHS and sharing best practice and so on?

[109] **Vaughan Gething:** Well, I don't think you'd see a budget line that says 'innovation and improvement' because, actually—. And I will tell you that I am driving innovation and improvement, but the reality is that the biggest drivers for innovation and improvement are our staff, because they're the ones who come up with the ideas about improvement. The challenge over, say, for example, the referral-to-treatment example I gave in eye care—well, actually, it wasn't that I said, 'I've got a great idea; let's change this'. It actually comes from staff, and it comes from people saying, 'We think there's a better way to do this', and the third sector also saying, 'We think the way you currently run your system doesn't provide the best outcomes for patients and it doesn't drive the right sort of clinical behaviours.' So, how do we do that? It's about, if you like, systems innovation, as well as, if you like, service innovation then as well, and we see that in a whole range of the things that we do. Every health board has their own awards for staff, which I think is a really important way not just of saying 'thank you' but of recognising

innovation. In the NHS awards that we have, the NHS Wales Awards, we look at innovation that has already taken place. And actually, what's really important is those awards are now very clearly run on the basis of promoting prudent healthcare examples of how we drive a set of values to deliver greater efficiency. Our challenge then still remains: how do we get those examples of what looks like good practice and deliver them on a broader and deeper basis with real pace and scale? You'll have seen this within your own health board in the use of telemedicine. There are really good examples of telemedicine across the service. The frustration is that, actually, we're pretty certain that we could have a much wider spread. That requires investment in IT systems and infrastructure, but that would provide much greater efficiency in the way that staff and patients have their time used and the outcomes that we then deliver for people.

[110] **Rhun ap Iorwerth:** Okay.

[111] **Dai Lloyd:** Hapus? **Dai Lloyd:** Happy?

[112] **Rhun ap Iorwerth:** Yes, for now, thank you.

[113] **Dai Lloyd:** Keep them keen. Turning to social care—Dawn is the queen of social care.

[114] **Dawn Bowden:** I wish. Thank you, Chair. Some stuff around cost pressures: obviously the different allocations, and the imbalance in the allocations between local government and the NHS, are well known—we understand the particular pressures in local government—but is there the potential for that to lead to difficulties in progressing and speeding up the process of integration, because of that budget imbalance?

[115] **Rebecca Evans:** Vaughan and I are always very keen to take a whole-system approach and to look at health and social care as equal partners. Actually, that was one of the parts of the parliamentary review, and one of our requests was that health and social care are considered and treated as equal partners, because we know that when there's pressure in one part of the system, actually it leads on to pressure in another, back and forth and so on.

[116] So, we've always seen them as equal partners, but we've also highlighted social care as a sector of national strategic importance, and that's driving a lot of the change that we're delivering, especially through the

additional investment that we're putting into the sector as well. I think that the intermediate care fund of £60 million this year is absolutely crucial in terms of starting to drive that change, and it's been warmly welcomed by all of the partners who use that fund. But, also, we've given a commitment in our manifesto to retain the integrated care fund for the lifetime of this Assembly, so I think that gives those partners involved in those regional partnership boards the confidence that they need to plan for further change over the coming years.

[117] **Dawn Bowden**: Can you just explain a little bit more about how shared budgeting—is there shared budgeting around health and social care? How is that working? Is that something that we ought to be looking at if we're not already doing it?

[118] **Rebecca Evans**: The intermediate care fund in itself is a shared budget for health and social care, but they are also able to bring in other partners such as housing, the third sector and so on. The regional partnership boards will decide how to draw down that money and how to spend it locally. We know that it is driving change elsewhere, so health and social care are teaming up to pool budgets in other areas as a result of seeing, actually, the way in which it is delivering change. It has to be change on the front line. But also we have the pooled budget requirement now, which I spoke of earlier, as of April next year, for adult social care. As I described, this is going to be a big change in the way in which we commission adult social care placements, and that is joint commissioning.

[119] **Dawn Bowden**: Is that not meeting with any resistance—everybody seems to be quite happy with that arrangement?

[120] **Rebecca Evans**: On the whole, health and social care are very keen to work collaboratively and integrate where they can. I think it's fair to say that some local authorities would prefer to integrate directly with health on a local authority footprint rather than the regional partnership footprint with regard to pooled budgets for April 2018. However, the legislation has been really clear, and we've been very clear as Government, that we will be requiring pooled budgets on a regional partnership board basis—so, the health board footprint.

[121] **Dawn Bowden**: Okay—sorry, Albert was going to say something.

[122] **Mr Heaney**: Just to come in to support all of that, as the Minister

describes, one of the really important aspects of a regional pooled budget is the ability around care homes to come together—strategic commissioning. Some of the market analysis that the Minister's had done shows us the opportunities for both local government and health, working together with the third sector and the independent sector, to really deliver that change agenda, working with the quality that's required and the resources in the right place at the right time. So, it's at scale—moving away from, sometimes, an individual boundary, which is important to local government, but the opportunity that exists in terms of the scale.

[123] **Dawn Bowden**: Do you see a role, then, for the Welsh Government to be driving that strategic change, or is that something that you see very much happening at a local level? Obviously, the delivery is at a local level, but what is Government's role in terms of driving that strategic change?

[124] **Rebecca Evans**: We are driving that strategic change through legislation and through the requirements that we have in the legislation. However, we're also keen to support that change as well, and support health and social care to work more closely together. We've done that through our regional partnership board training days, for example. We had one specifically on pooled budgets. So, we realise that this is a difficult, complex task, and we are there to provide as much support and guidance as we can to local authorities and health in terms of delivering this.

[125] **Dawn Bowden**: Okay, that's fine. I've just got two more quick questions, Chair, if I may. You've alluded already to the additional funding, Minister, but, on the additional £25 million in particular for social care, what were the particular outcomes you were looking for as a result of that?

[126] **Rebecca Evans**: The additional £25 million that was announced in the budget is very much in the same kind of field as the money that Vaughan was talking about earlier, in terms of keeping the system going. We heard very clearly the messages from the workforce, from providers, from local authorities about the quite severe pressure in the social care system, which is why that £25 million was provided to local authorities to help them to meet those pressures. That £25 million went through the revenue support grant, so it's for local authorities to determine on a local basis how they use that money to meet that need.

[127] However, we have been much more prescriptive in terms of some of the other additional funding that we provided to local authorities. The £20

million of funding that we announced as a result of the consequential funding that we received—£9 million of that joins the £10 million I announced earlier this year, which was to help local authorities meet the pressures of the national living wage. That, in this first year, is provided through grant funding, so we've been clear with local authorities about the outcomes that we expect to receive. We see it very much as a tripartite agreement between ourselves providing funding, also local authorities commissioning for quality, and providers themselves investing in their businesses and their staff.

[128] **Dawn Bowden**: So, is it still a bit early to see whether all of that is panning out in the way that you wanted it to at the moment?

[129] **Rebecca Evans**: Well, it's very early at the moment. We provide the money in two halves. So, the first half has gone out to local authorities with regard to that £10 million, and then we'll be requiring them to report to us on various measures to demonstrate that they are helping to meet the pressures of the national living wage before we can free up the second part of that. So, we'd expect to see improved quality and sustainability in the workforce, reduced staff turnover, improved conditions for staff, and so on. But then, alongside that money as well, we've put £8 million into improving outcomes for children in care and reducing the number of children in care, and, again, this is part of grant funding, so we're being very specific as to what we wish to see. We wish to see expanded, integrated family support services for families and for children in care, or for families. This will prevent children coming into care and increase the capacity that we do have for those children who are currently in care. Also, we will be expanding the Reflect project, which started out in Newport and is being expanded to the whole of Gwent now. That's to help mothers who have multiple births taken into care, which is obviously extremely distressing for the mums involved, and then increasing the number of children that we have in care. So, this is a really exciting project that this funding has allowed us to expand across the whole of Wales as well.

[130] We'll also be providing funding to ensure that children, or young people leaving care, are now able to be supported by workers up to the age of 25 rather than 18. So, that's helping in their transition into adult life, and, again, hoping to improve the outcomes for those young people. Again, we'll be seeking to ensure that local authorities reinvest those savings into prevention.

[131] Just to complete the £20 million, the final part of that was the £3 million for a national approach to respite for carers as well. Again, we're looking at what we might be asking local authorities to deliver there. We haven't set out those parameters yet.

[132] **Dai Lloyd**: I think young Lynne has got a question on this point.

[133] **Lynne Neagle**: Has any of that money for children in care gone into enabling local authorities to provide adequate support for kinship carers?

[134] **Rebecca Evans**: This funding hasn't actually gone out to local authorities yet, because we are still working out the parameters of what we will be asking, but it will be very much in the field of what I have described to you. We can certainly look at the pressures on kinship carers. I know we've had a discussion about this outside.

[135] **Lynne Neagle**: Because they're not getting the same amount of money as non-family foster carers.

11:00

[136] **Rebecca Evans**: That's right. We can certainly look at this. I think Albert also wants to come in.

[137] **Mr Heaney**: Just to add to the Minister's comments, the ministerial advisory group that's currently being chaired by David Melding is actually looking at these issues. So, that's being currently looked at in terms of kinship care, special guardianship and issues of that nature.

[138] **Dai Lloyd**: Okay. Dawn.

[139] **Dawn Bowden**: Just one final question, Chair, around domiciliary and the care home sector. Certainly when we were taking evidence on the winter preparedness sessions, there were some concerns being expressed about the resilience of both those sectors, and I really wanted to get your views on whether you're satisfied with the resilience of both the domiciliary care and the care home sectors, and, if not, is that primarily a financial issue, or are there some sort of structural issues as well around those sectors?

[140] **Rebecca Evans**: I've been very clear that I do understand the fragility of the social care sector as a whole, so, domiciliary care and also the care home

sector as well. I think the answers lie in a number of areas. Funding is an important part of it, and I described the additional funding that we are providing. I should have also mentioned the fact that we are allowing local authorities to access further funding by increasing the cap on domiciliary care from £60 to £70 this year. That should ensure that local authorities are able to claim about £4 million there, as well, which also will help with the pressures, and we've also provided local authorities with an additional £4 million—more than £4 million—to meet the pressures, as a result of the furthering of the capital limit to £30,000 as well. That was a manifesto commitment and we thought it only right to provide that additional funding to local authorities. So, funding is part of it, and I think that Welsh Government is playing its part there.

[141] Also, there's a role for commissioning, and we're trying to change the way that care is commissioned so that we commission for quality, and we're doing that through a number of ways. I described the adult social care placement pooled budgets from next year, but we've also had the opportunity to develop, with the sector and with local authorities, a commissioning concordat as well. So, that's a tripartite agreement, again, about commissioning for quality and investing in staff, investing in business, and I was able to launch that in partnership with the Homecare Association very recently as well.

[142] The third part of it is regulation, and we have the Regulation and Inspection of Social Care (Wales) Act 2016 to drive up standards in the sector. We're consulting on the second phase at the moment, which is about what standards we require from the people responsible for businesses, but also the kind of quality standards of the care home itself—so, the environments in the care homes—so that people can have a good understanding of what should be expected there. And we're also consulting on the issue of zero-hours contracts as well, because we know of the link that these have with the quality of care that people receive, particularly in domiciliary care, where there can be a high turnover of staff and so on.

[143] So, there's a role for funding, commissioning and regulation, and phase 3 will be our final phase, then, in terms of delivering the regulation and inspection of social care Act, and that will be looking at market stability: what information we will require from providers in order to give Welsh Government, actually, a better oversight of the market, and we will understand where we have pressures in the system. We will have a duty, then, to inform local authorities if we think that there are businesses that are

weak and that could cause a problem locally. So, I think that will give us much better market oversight. I think that covers most of it.

[144] **Dai Lloyd:** Okay. Before we move on, in terms of budgetary scrutiny and the living wage situation regarding social care support workers, it's a very laudable aim, but how did you arrive at the £19 million figure? It seems to me that it could ideally be a lot higher than that, so I was just intrigued as regards how the £19 million came about.

[145] **Mr Heaney:** We had a number of round-table events. The Minister asked us to meet with all the partners in the sector, which we went through. The original knowledge and analytical services projections were between £14 million and £22 million, and then it was from a series of conversations. Part of the solution was investing money, which Welsh Government has done, but part of the solution is also looking to the sector in terms of how it can contribute to aid staff development, pooling, sharing, perhaps, back-office services as well. So, it was a wider conversation on the pathway to sustainability.

[146] **Dai Lloyd:** A lot of it, though, is the actual contracts on the ground, so that if you're putting downward pressure on care support workers to deliver services in 15 minutes as opposed to 30 minutes because of financial considerations, how is that built into your £19 million deliberation?

[147] **Mr Heaney:** In terms of the 15-minute visits, in the passing of the Regulation and Inspection of Social Care (Wales) Act 2016 it was quite explicit, and it comes from Lindsay Whittle, Assembly Member, in terms of one of the amended motions that came through very successfully, and put the terms and conditions into what can be done and what can't be done so that the foundation is placed to ensure that the care provided is sustainable.

[148] In terms of the financial packages, we work together with section 151 officers across the Welsh Local Government Association and the chief executive of the Welsh Local Government Association. So, in terms of the funding amount that's gone in to meet that particular need, that is a substantial investment. I think it covers what we will be doing, as the Minister explained earlier on, namely having very detailed monitoring returns that will come back to us so that we can monitor and make sure that that goes into the front line, because, in a sector that has around about a 30 per cent turnover, then we are investing a tremendous amount in terms of new staff recruitment and trying to get retention, and this is a way to create what we

believe is that enhanced sustainability and continuity of care.

[149] **Dai Lloyd**: All that's accepted, but there is still a very tight financial situation with regard to the living wage, and that's why we're losing staff. They've been trained, and then they just can't carry on. So, I presume the £19 million was based on numbers of care support workers, the hours worked. There's a mathematical equation; it wasn't just plucked out of somewhere just after a meeting.

[150] **Mr Heaney**: It wasn't just plucked out of somewhere. It's from the—. I mentioned the knowledge and analytical services as well that assisted us in the statistical analysis of the figures that were acquired.

[151] **Dai Lloyd**: Okay, thank you.

[152] **Rebecca Evans**: Can I just make a quick point on the delineation between care time and travel time? We've been clear in our letter to local authorities that accompanies that extra £19 million for the national living wage that, actually, this money might be used to ensure that social care providers do delineate. But, actually, this would be a precursor to some of the work that we're consulting on at the moment as part of phase 2 of the regulation and inspection of social care Act, which relates to delineation of care time and travel time. So, we will be requiring providers to be very clear in terms of their workforce—what time they would be expecting them to travel, and so on. We know at the moment that the workforce tell us that, actually, they feel pressured to move between jobs because they're not always paid necessarily, even though they should be, for time between, for travel, and so on. So, this will be explicit in the law.

[153] **Dai Lloyd**: That's why it's an important point. Anyway, time is going on. Budgetary issues as regards prevention—Julie.

[154] **Julie Morgan**: I wanted to go back to the issue of prevention. I think you do say in your paper that it's difficult to identify all the ways that the money is actually spent on prevention. Do you feel it's possible to see the money that's going into prevention and the outcomes? Is there any way of measuring that?

[155] **Rebecca Evans**: Last year, the previous Minister for Health and Social Services published the national outcomes framework for public health, and that's a really important document for Welsh Government but also for our

partners in the health boards and in local authorities, and so on. It has a series of 43 overarching outcomes, and I'd be happy to send a copy of that document to the committee to have a look at after today's meeting. But it does look right through the whole span of life, from years of life and years of health, so life expectancy at birth but also healthy life years expectancy at birth, mental well-being amongst children, mental well-being amongst adults, and also a fair chance for health as well. So, measuring that gap in terms of life expectancy at birth between the most affluent people and the poorest people as well.

[156] It moves on then to look at living conditions that support and contribute to health, both now and for the future—things such as the gap in employment rates for those people with long-term health conditions, and so on. And it then moves on to look at resilient, empowered communities—so, people who volunteer, the number of people who feel lonely—and to look at the natural and built environments, which support health and well-being, by looking at the quality of the air that we breathe and the quality of housing, because we know all of these things come together to have a preventative impact.

[157] It looks at ways of living that improve health. So, we're measuring in our public health outcomes framework adolescents who smoke, for example, adolescents who drink alcohol, adults who drink above the guidelines, smoking in pregnancy, breastfeeding at 10 days, which I know is something that you have a particular interest in as well. And, then, finally, health throughout the life course, so healthy ageing, for example, life satisfaction amongst older people, older people of a healthy weight, hip fractures amongst older people. That's just an overview of some of those 43 aspects that we're measuring in terms of getting a good understanding of how these preventative measures can be demonstrated through outcomes.

[158] **Julie Morgan:** So, how do you actually measure those?

[159] **Vaughan Gething:** Can I just make one brief point about measuring improvement and prevention? You know we started the inverse care law work a couple of years ago, with pilots in Aneurin Bevan and Cwm Taf, and maybe it would be useful to give the committee an update on that. I think we've got some figures that we can share on what we think we've actually done with those people. So, it's that point about, in the middle of your life, it's still possible to make significant improvement in your own health outcomes, and I think that's been quite a successful example. It's been rolled out in the

Abertawe Bro Morgannwg health board area, but we'll send a note to committee, because I think would be genuinely useful to share with you.

[160] **Dai Lloyd:** Thank you.

[161] **Rebecca Evans:** The outcomes document will let you know how we access these data as well. So, they're things like Office for National Statistics data, national surveys, research in universities and so on. So, it's a robust set of data.

[162] **Dai Lloyd:** Okay. Julie.

[163] **Julie Morgan:** Right. To carry on with the different groups that we want to reach in terms of prevention. Obviously, one of the key things is physical activity as prevention. How do you feel that that is being addressed, and do you feel that Sport Wales is achieving the goal of reaching the hard-to-reach groups that don't naturally physically exercise?

[164] **Rebecca Evans:** Well, this is one of the key questions that we've asked the panel who are undertaking the review of Sport Wales to look at. We've asked them to explore whether the current vision, aspirations and strategic intent of Sport Wales actually meet the Welsh Government's aspirations and priorities and objectives. And we've been really clear in that piece of work that, actually, our priorities are about getting Wales active, and particularly reaching those communities who don't often partake in physical acitivity and so on as well. And I've been clear with them in the remit letter that that's where we expect them to be undertaking a lot of their work and a lot of their effort. We should be having the review formally submitted to Welsh Government in the next, I would say, week or so, and there will be an opportunity then to have a discussion on it as well. So, we'll have a clearer idea as to what the findings are of that review panel, and that will—

[165] **Julie Morgan:** And that will particularly look at reaching these different groups.

[166] **Rebecca Evans:** Yes, that very specific question.

[167] **Dai Lloyd:** Okay. Julie.

[168] **Julie Morgan:** Thank you very much. And, then, my final question is about the financial impact of legislation and the costings of bringing in

legislation. For example, the figure of £198,400 was submitted to this committee for the implementation of the Public Health (Wales) Bill. Now, what does that figure cover?

[169] **Rebecca Evans:** The regulatory impact assessment described in detail what we would expect the costs to be as a result of the public health Bill. But we've been quite cautious in the way in which we've looked at those costs as well. So, whenever we've had to estimate, we've estimated at the upper end of the scale. So, it could actually be that the costs of implementing the Bill, or the Act, as it will be next week, actually, might be lower than we—

[170] **Julie Morgan:** You've covered for unanticipated costs.

[171] **Rebecca Evans:** Where we have anticipated costs, we've gone to the upper end as to what those anticipated costs might be. So, it might be that they will be less. And, so, the kinds of things that we've anticipated the costs for would be staff time for Welsh Government officials in terms of dealing with the huge range of regulations that will now sit underneath it, and the guidance, producing signage and the development of the registers, which were part of the Bill as well. So, there'll be that work, but we have costed all of that into the regulatory impact assessment. And we've also been really keen, where possible, to give local authorities the chance to lower their costs as well in the Bill, for example, by having joint training days for parts of the Bill that actually have a lot of synergy, such as the part on intimate piercings, for example, and the part on special procedures. So, there will be opportunities for local authorities to keep the cost as low as possible as well.

[172] **Julie Morgan:** Okay. Thank you.

11:15

[173] **Dai Lloyd:** Okay. The final section: a quick trot through capital investment with Lynne.

[174] **Lynne Neagle:** Is there enough capital money there to enable health boards to meet their planned aspiration, including major projects?

[175] **Vaughan Gething:** Well, the two biggest major projects we have are the Velindre Transforming Cancer centre and the Specialist and Critical Care Centre. Those projects are proceeding. Our challenge is that, across Government, even with some loosening in capital, there are real challenges

around the whole capital programme. It wouldn't be right to say, 'We have lots of money to throw around.' So, there's still real tight control on the capital programme, and I am a bit concerned about our ability to re-engineer parts of our system because we actually think that investing in primary care could and should be a really useful way to actually get services to work together and to provide revenue savings. Also, we think that the Specialist and Critical Care Centre, for example, will not just deliver better care; we actually think it should deliver some revenue savings as well. That's really important in the way we use capital. So, there are always going to be concerns about the way in which the programme is managed. I mean, historically, as a Government, we have actually come to the end and realised we've got a small underspend at the end of the year. That's not unusual for most organisations, not even in the private sector. But, actually, there's an even bigger need to make sure that in our capital programme we deliver on time and in budget, because otherwise, we'll potentially compromise other parts of the programme. But those two major projects are going ahead. Obviously, the Velindre one is a different model with a new Welsh mutual investment model.

[176] **Lynne Neagle**: And, clearly, being able to have enough capital money is important for service transformation, isn't it? You've alluded to that. Are you saying, then, that you are confident that you have just about got enough money in the system to achieve those transformations?

[177] **Vaughan Gething**: We could always do more if we had more, but the money that we will use will have to be used in a way that transforms services. The previous health Minister, who is now in a different role in Government, who has an interest in money, was really clear in the parameters he set, which I've continued with, that the use of capital has to be able to deliver revenue savings and actually deliver service transformation as well. Those are still important tests. The architecture we have, with an investment board that looks over these decisions, means there are real tests there as well. It's why some of our decisions take time to get through, to be clear that the evidence really is there, and that they'll deliver against the parameters they're set. I would always like more to be able to spend on capital because I think that we could spend lots of money very usefully in primary care, but there are real limits to what we do have available to us as a Government, let alone within the health and care field.

[178] **Lynne Neagle**: And you referred to the Velindre model, which is a mutual model. Can you tell us what the current state of play is with that, and

whether there's any potential to take that model and use it elsewhere?

[179] **Vaughan Gething**: Well, interestingly, Velindre is one of the first big projects to use that model. I was at the launch day for that with people who are interested in participating, with both Mark Drakeford and Kirsty Williams, because the other area that we're looking at to use it as finance is education. I know we've got a range of our school buildings that we want to transform as well, but it's actually finding capital to do that. So, we're looking at those two areas first, as big areas where it could be used, and we also learn lots more from it. But, at the moment, it's proceeding.

[180] We've met with people at Velindre as well. People are interested in actually designing the scheme as well. So, at this point, I'm as confident, I think, as I could and should be that the model should work; that ONS aren't going to be—. Part of the issue about having the model ready was to make sure that we didn't get into a position where ONS reclassified the money. Because that's what happened in Scotland: they had a different model of investment and, after they'd actually spent money, ONS reclassified the money and I know that the Scottish Government had to find about £0.5 billion of capital moneys within their own real moneys on the budget. So, that was a real risk and one I had to redesign our own model on, so it's slightly different to what we initially wanted it to be, but we think, from the conversations we've had, that we should be able to do that in that way and not have all of that money on book, and, at the same time, not be paying out the sort of moneys we would have done if we'd have gone down the traditional PFI route as well. So, it's definitely a better option, but it does come with a revenue cost attached to it. But, otherwise, we just choke off completely our ability to deliver those larger capital projects.

[181] **Lynne Neagle**: And just finally, your paper talks about an active programme of disposal of surplus land across NHS Wales, and joint working with other agencies. Can you tell us about the governance arrangements that are in place to take forward that work? Also, what assurances can you offer that any money that's then brought back into the system is being used to deliver service improvements?

[182] **Vaughan Gething**: Well, perhaps I'll ask Andrew and Alan to comment, but I think there's an important distinction to draw between our approach here in Wales. We want to see reinvestment made in partnerships, for example. You'll be aware that the previous housing Minister was looking at the ability to have surplus public land and housing having an early call on

whether that land could be used to deliver against our affordable housing targets. But also, the reviews being done in England on the disposal of land in the NHS estate didn't necessarily guarantee to deliver resources back into the public purse as well. So, that isn't the approach that we're taking here. I think there's a proper distinction to draw. I don't know if Andrew or Alan want to give you some more detail.

[183] **Mr Brace**: On the governance side, I think all disposals of land and property have got to be approved by Welsh Ministers under the Act. So, to some extent, the boards need our approval, and part of that requirement as well is that everything over £0.5 million, in terms of reinvestment, has also got to be approved by us. As the Cabinet Secretary said, we've got a fairly rigid set of investment criteria we would use and, therefore, apply to any sort of income that we would receive from disposals, and how that was going to be reapplied back into the service.

[184] **Lynne Neagle**: And does it always stay within the NHS? It doesn't go into any other broader capital pot in Welsh Government.

[185] **Mr Brace**: I think all of these things get factored at a Government level in terms of available capital and support or not, but generally the NHS would remain within the NHS.

[186] **Lynne Neagle**: Thank you.

[187] **Dai Lloyd**: Okay. Angela, your question about agencies, squeeze it in.

[188] **Angela Burns**: Thank you. We all know that we spend an awful lot of money within the NHS on agency staff. I just wondered if you could explain to me a little bit about that process. Because my understanding, which is entirely incomplete, but from talking to particularly nurses and the nursing profession at large, is that a lot of our trained nurses will go and also work sometimes either on bank or for an agency and for another trust, because they're unable to work within their own trust and get appropriate overtime rates. I wondered if there had been a body of work undertaken that actually examined this to say whether or not it would be cheaper in the long run for the NHS to say to a nurse, 'I'd rather you stayed here on the ward and in the hospital that you know and we pay you appropriate overtime,' rather than, in order for that person to earn extra money, them having to go off to the trust next door and we end up paying agency fees or they have to go through bank, where they actually earn less money. I just wanted to try and

understand that whole situation a little bit more.

[189] **Vaughan Gething**: I'll ask Andrew to come in, but I can just start by saying, 'Yes, that is actively in our minds.' There's work ongoing and I expect to receive formal advice in the near future.

[190] **Dr Goodall**: I would distinguish our focus on bank as opposed to agency, because of course bank is a local issue for management. However, we do feel that a system that has been more based around the individual health board boundaries—there is an opportunity for both regional and Welsh banks to be in place, which I think will address the issue that you're raising about consistency of the framework. But, yes, we're doing some particular work with the NHS in Wales. We've been looking to put more controls in place, we've been looking at different and more innovative models of service, we've been actually learning from the English and Scottish systems' experiences, and there'll be some ministerial advice coming up for a refreshed policy in Wales.

[191] And, absolutely, what we want to focus on is the extent to which we can rely on our own employees and give an environment for our own nurses to work within our own services. And I hope that will be underpinned by broader issues about recruitment that would give people support as well. So, the 'Train. Work. Live.' campaign is obviously looking to attract more nurses in, our expansion of nurse commissioning numbers also gives some kind of confidence, and the retention of the nurse bursary also gives people the opportunity to feel that they're going to be looked after in the Welsh context at this stage. And, we're hoping that, as part of the advice to the Minister, there will be some further clarification on this Welsh bank approach, which I think will be quite innovative.

[192] **Angela Burns**: Will the Welsh bank approach be looking at the rates that a nurse would be paid and whether or not that rate is comparable to what he or she would have earned in their full-time job for someone, because I think that's quite an anomaly, isn't it?

[193] **Dr Goodall**: Indeed, the advice going up will be to remove the reliance on agency, although there are some more substantive service issues for using agency on a longer term basis, and it will introduce a more consistent framework across Wales so that people don't pick and choose between individual health boards and individual services. So, that is the underlying intent.

[194] **Angela Burns:** And just a final question on agency: the agency costs that we see within the NHS, which are huge, are they mainly for nursing or general medical staff or are there also substantial amounts of that for staff elsewhere within the NHS organisation? Do you have that breakdown?

[195] **Dr Goodall:** Just to continue the response, it's a mixed picture, but the predominant pressures are around medical and nursing agency use, and, in broader terms, there is some peripheral use of other members of staff. Our general approach is to see whether we can shift all of those, but, obviously, in terms of bringing resources back into use and also our focus on the quality of care that's provided, the focus for us is really around medical and nursing. There are different reasons, so, you can have a short-term issue and a concern about quality on a particular ward, and people making those sorts of judgments. I think there are different ways of supporting that in terms of the local operational management approach. I think there are more tricky issues when you're looking at, perhaps, the fragility of some services that have been reliant on locums over a longer time, so I look at areas, for example, about the support that underpinned maternity services in Betsi Cadwaladr, which required some longer term locums, or indeed around Withybush hospital with some of the locum arrangements. However, having said that, positively—and I think, again, this is, hopefully, with a more assertive Welsh offer that's in place—we've actually seen staff who've come in initially as locums, perhaps on a slightly enhanced rate, wishing to be remaining locally within substantive roles. I think there's been success there with both Betsi Cadwaladr, and, actually, more recently, in Hywel Dda, where people have converted to become NHS employees.

[196] **Angela Burns:** Thank you.

[197] **Dai Lloyd:** Ocê. Diolch yn fawr. A dyna ddiwedd y sesiwn, felly diolch yn fawr iawn i Ysgrifennydd y Cabinet ac i'r Gweinidog a hefyd eich swyddogion am eich presenoldeb y bore yma. Mi fyddwch chi yn derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau ei fod e'n ffeithiol gywir. Ond, gyda chymaint â hynny o eiriau, diolch yn fawr iawn i chi am eich presenoldeb. Diolch yn fawr.

**Dai Lloyd:** Okay. Thank you very much. And that bring the session to a close, so thank you very much to the Cabinet Secretary and the Minister and your officials for your attendance this morning. You will receive a transcript of this meeting so that you can check it for factual accuracy. But, with those few words of thanks, thank you again for your attendance.

11:26

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

[198] **Dai Lloyd**: Rydym ni'n symud ymlaen i eitem 3, papurau i'w nodi. Mi fydd Aelodau wedi gweld y papurau i'w nodi. Unrhyw bwynt i'w godi? Nac oes.

**Dai Lloyd**: We move on now to item 3, papers to note. Members will have already seen these papers to note. Any points to raise? No.

## 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

*Cynnig:*

*bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).*

*Motion:*

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

*Cynigiwyd y cynnig.*
*Motion moved.*

[199] **Dai Lloyd**: Rydym yn symud i eitem 4, cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod a mynd mewn i sesiwn breifat fyr. Pawb yn cytuno? Diolch yn fawr.

**Dai Lloyd**: Therefore we move to item 4, motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting and to go into private session. Everyone agreed? Thank you very much.

*Derbyniwyd y cynnig.*
*Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 11:27.*

*The public part of the meeting ended at 11:27.*