Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Cyfrifon Cyhoeddus

The Public Accounts Committee

10/7/2017

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Nick Ramsay Bywgraffiad|Biography	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Alan Brace	Cyfarwyddwr Cyllid, Llywodraeth Cymru Director of Finance, Welsh Government
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol a Phrif Weithredwr GIG Cymru Director General/NHS Chief Executive
Jeremy Morgan	Swyddfa Archwilio Cymru Wales Audit Office
Matthew Mortlock	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

Mike Usher	Swyddfa Archwilio Cymru Wales Audit Office

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

Jonathan Baxter	Y Gwasanaeth Ymchwil Research Service
Fay Bowen	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Katie Wyatt	Cynghorydd Cyfreithiol Legal Adviser

Dechreuodd y cyfarfod am 14:00.
The meeting began at 14:00.

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

[1] **Nick Ramsay:** I welcome Members to this afternoon's meeting of the Public Accounts Committee. Headsets are available for translation and sound amplification. Please ensure any electronic devices are on silent. In an emergency, follow the directions from the ushers. One apology has been received today from Lee Waters, and there are no substitutes. Do Members have any declarations of interest they'd like to make at this point? No.

Papurau i'w Nodi
Papers to Note

[2] **Nick Ramsay:** Item 2, and papers to note from the last meeting, and there's quite a bit to note. First of all, the minutes of the last meeting held on 3 July—happy with that? Yes. Secondly, we have a letter—Her Majesty's Revenue and Customs have written advising that Jim Harra, director general for customer strategy and tax design, has been appointed as additional accounting officer with responsibility for the WRIT—the Welsh rate of income

tax. This is a standard notification sent to me as Chair of the committee. Are we happy to note that letter?

[3] Next are the governance arrangements at Betsi Cadwaladr University Local Health Board and the Auditor General for Wales report, 'An Overview of Governance Arrangements', from 29 June. The previous committee undertook an extensive inquiry into governance arrangements at BCUHB and held regular monitoring evidence sessions with the health board and the Welsh Government as part of the follow-up work. As part of that monitoring, the previous committee also undertook an inquiry considering the overall governance of Welsh health boards and recommended that consideration for any further work on governance issues be passed to the Health, Social Care and Sport Committee for inclusion in that committee's regular scrutiny of the Minister. Are Members happy to note the report and agree that we forward the report to the Health, Social Care and Sport Committee to consider as part of its regular scrutiny of the Cabinet Secretary? It seems to be an appropriate committee to look at that.

[4] Back to the Welsh Government's funding of Kancoat Ltd, and we've got a letter from the First Minister from 28 June 2017. That was a response to my letter of 11 May regarding the ministerial code, which has been an issue that has been rumbling on. That was raised as part of the committee's work on Kancoat. The First Minister has advised that he'll be writing to all Cab Secs and Ministers, asking that they are mindful of decisions taken on matters outside their constituencies that might be of incidental benefit to their constituents and that if the benefit is considered significant enough, that it should be referred to the First Minister for advice on handling at the outset or at an appropriate point. Happy to note? Good.

[5] And, moving on, Natural Resources Wales's response to the committee's report—I'm pleased to say that NRW have accepted the three recommendations contained in the committee's report and have also provided an action plan showing how they intend to take forward each of the recommendations, including the timelines and the actions due to be completed by the end of October 2017, at which point NRW will provide an update on their progress. That's going to be in November, and a Plenary debate on the committee's report is scheduled for 19 July. Happy to note the response from NRW? Good stuff.

14:03

Gweithredu Deddf Cyllid y GIG (Cymru) 2014: Sesiwn Dystiolaeth
Implementation of the NHS Finance (Wales) Act 2014: Evidence Session

[6] **Nick Ramsay:** Our witnesses are waiting patiently, as we reach the substantive evidence session for today, and that is item 3, the implementation of the NHS Finance (Wales) Act 2014. This is our first evidence session, and can I welcome our witnesses? Thanks for being with us today. Just a bit of background: the auditor general's report was published on 6 July, and the previous committee, our predecessor committee, were aware that this piece of work was going to be happening and recommended that we, the successor committee, considered any lessons arising from the report on the impact of the NHS Finance (Wales) Act 2014. As 2016-17 is the first third year following the implementation of the Act and as the 2016-17 accounts of four of the seven health boards are showing a deficit for year 3, I feel it's important that we consider the findings of the report and discuss this with the Welsh Government. At that point, can I welcome our witnesses? Thanks for being with us today. Would you like to give your name and position for the Record of Proceedings?

[7] **Dr Goodall:** Prynhawn da. Good afternoon. I'm Andrew Goodall, I'm the director general for health and social services. I'm the NHS Wales chief executive.

[8] **Mr Brace:** Afternoon. Alan Brace, director of finance for health and social services.

[9] **Nick Ramsay:** Great, thank you for that, and thank you for being with us today. Can I kick off the questions from Members? Firstly, quite a simple question: despite the announcements of extra funding, which were in response to the Nuffield Trust and Health Foundation reports, the Welsh Government has needed to allocate additional in-year funding this time; can you give an explanation for that?

[10] **Dr Goodall:** If I start, Chair, I'm sure Alan can help me, maybe on some of the technicalities on the financial side. Obviously, we go through an annual allocation process. One thing I would emphasise from the start is that, although it can seem that our whole system and our scrutiny and even the efforts of the NHS often are placed on the allocation to come, I think we've been trying to organise our system in Wales and reminding everybody about the certainty that they do have for the budgets that are in place. These are significant budgets for large organisations, and they are obviously

significant in terms of the impact and implications that they have, not least as they are approaching 50 per cent of the Welsh Government budget in overall terms.

[11] So, we are, on the one hand, I think, trying to orchestrate better use of the broader allocations to respond to reports, which I'm sure we'll touch on, like the Health Foundation and Nuffield Trust reports, which are highlighted within the review and which I think have changed some of the current approach and financial methodology of our system. We also have to ensure that we are able to respond to more immediate issues that occur during the year. Those issues may range from needing to step into areas where there have been material drug announcements, perhaps, that hadn't been anticipated—. Certainly, if we look back to 2015-16, we had a benefit, actually, of consequentials from the UK budget and there was an opportunity for us to put in resources, which, although they were arguably in-year and additional, were quite significant enablers for us in terms of areas that we could really do a little bit differently—areas like primary care. It was the start of the intermediate care fund that colleagues will have seen referred to in previous sessions. We had an opportunity to do something different in mental health and, yes, within that, there was a need to indicate some support for individual organisations and that did happen through last year, for example, in 2016-17, in respect of two of the health boards in Wales where that was part of the budget settlement.

[12] As I hand over to Alan just to respond to that question, I would really emphasise that the question is about how we use all of the resources. That's the bulk of it, clearly, within a certainty in funding that is already in place, and then we need to ensure that we are able to target and have advantage of the additional funding into the system.

[13] **Mr Brace:** Yes, just on the point of in-year funding, I guess I just want to distinguish between the main expenditure group, which is the overall budget for the health and social services group, and then the NHS. So, there will be some in-year changes that don't affect the NHS. So, last year, there were some UK changes around the prescription pricing regulation scheme that meant that we, along with others in the UK, were losing income. That was recognised and we had some in-year support to cover that.

[14] In relation to the NHS, I think the bulk of the allocations are out early. I think that boards can now plan with a lot more certainty. They get clear indications. This time last year, I was the finance director of Aneurin Bevan

health board. I had £1.1 billion to plan on. I had clear indications from Welsh Government early about what I could expect for in-year cost pressures around pay and non-pay. So, most of what I needed to know to plan was known well before the start of the financial year.

[15] There will be things that will change as the year goes on. I guess health is a complex business. There will be things that will be phased as the year goes on. A good example from last year would be the new treatment fund. That was always designed to kick off in-year, so funding was made available to cover that. There will be some cost pressures and decisions made around new drugs that, again, there may be a choice to fund centrally. So, by and large, most of the in-year adjustments now are for very specific priorities or linked to some very specific decisions around performance, again linked to plans.

[16] **Nick Ramsay:** Rhianon Passmore, did you have a supplementary?

[17] **Rhianon Passmore:** Thank you. You've mentioned your role in the Aneurin Bevan health board. Obviously, those accounts have been passed. In terms of that three-year flexibility—you've mentioned it a couple of times already—was that beneficial to you in terms of the ability to plan?

[18] **Mr Brace:** Yes, hugely. Not that when I was in Aneurin Bevan we decided to invoke some of that flexibility by bringing forward allocations, but, generally, it's almost a reinforcement to take a medium-term look because, really, the essence of the Act is, I think, for boards to understand the needs of their population, to develop and design services to meet those needs, to make a workforce available within those services and to do that within existing resources. So, clearly, the real task is to make sure you take a medium to long-term view of your clinical services and the needs of your population and, I guess, a reinforcement that you can have that flexibility around the way that you use resources. It's hugely helpful for planning and, actually, for us in Wales, moving away from the old market-driven commissioning and providing to a planning system—that was an important component, I thought.

[19] **Dr Goodall:** Chair, we've had to ensure that although the legislation, on the one hand, is quite clear, a lot of this is about the approach that we determine that we are going to take in terms of our oversight of the system. It would be right to say that the previous arrangements did feel as though it was all geared to dealing with the individual year in question. It was about

landing the accounts; it was about driving the performance areas. We've absolutely tried, through the integrated medium-term planning process, to make sure that our three-year plans do stretch our horizon, but it's really important that we're also able to steer that as officials by working with the organisations ourselves. So, our end-of-year reviews clearly, on the one hand, have to take account of performance issues, and these are more immediate to perhaps some of the milestones that are in place. However, we do ensure that we are looking forward for the organisation over a much longer period of time. So, I think three years has genuinely changed not just the attitude of the service; I think it's changed the way in which we've approached it as the Welsh Government. The trick is, I think, for some organisations, that it's important to even think more broadly than that. So, we've actually seen organisations starting to talk about their plans, for example, over the next 10 years, and some real ambition for what they want to change, even if we still have to convert it into a three-year plan.

[20] **Nick Ramsay:** I understand that. You mentioned the new treatment fund as an example of in-year spend, and I think everyone would accept that there are going to be instances where that's unavoidable, but this committee is revisiting this issue today within a broader setting because, clearly, it's been an issue before. Clearly, if there's a need for in-year spending, that need is there, but do you think, over time, that is a real challenge to developing the medium-term planning—financial planning—that the Welsh Government, on the one hand, so much wants from the health boards but then seems to be overridden, for whatever reason, each year with these in-year allocations?

[21] **Dr Goodall:** Well, I guess, in part, it's the scale of looking at what some of these allocations might represent. So, even where Ministers may make judgments that they want to seek to push further on performance, for example, and improve it, you look at some of the sums that have gone into this over the last two or three years or so—and in an individual year maybe £50 million, for example—in overall terms, that would still only represent something like about 0.7 per cent of the overall budget. So, although it helps and enables I think it gives the direction in terms of the Minister's expectations. I think the core issue is still about how you look to balance your resources and your plans within the overall funds that you're allocated. I think what we've been trying to see over the three years—and it's not there for all organisations—. We've seen a difference in respect of some of the organisations now, definitely in a more mature space. That's why we've got six out of the 10 organisations with clearly approved plans, and

demonstrating that they can manage performance, they can deliver service change, but actually, they can manage it within the budget. So, yes, we can always look to enable these issues and, over time, of course, our expectation will be to see, actually, that the non-recurrent level of funding would come down. I guess, in terms of core pressures, there may always be moments through the year when people actually decide that they want to drive things faster or quicker, perhaps, even though they're actually laid out in some of those individual plans. And I do think we need to allow for some of that flexibility, because these are very large and complex organisations. But the real discipline must be there about organisations understanding their duty and responsibilities to manage their finances, and there is an accountability associated with that.

[22] **Nick Ramsay:** How is the Welsh Government ensuring that its work on efficiency and prudent healthcare is linked to the three-year plans?

[23] **Mr Brace:** Shall I just cover a little bit of our approach and then just describe how this works through? So, in relation to efficiency, we're probably trying to tackle that at two levels. There's, I guess, what we would call technical efficiency, which would be the normal efficiency that the NHS would pursue around inputs and outputs. Can we get more output for the same input? Can we get the same output for less input? So, just the normal efficiency/productivity work. What we're doing on there is we've got a national efficiency board that is chaired by Andrew, and the various streams of work, which come from the NHS—they're tested, I guess, with senior officials in the Welsh Government and then it's about spread and adoption. So, we've got an efficiency and productivity framework that's been led by the chief execs and directors of finance, and that's currently in all plans. We've got some work around clinical variation that is being led by medical directors and, again, the expectation is that that would feature more systematically across the NHS in Wales. We've got work on rostering of nursing staff by the directors of nursing, work on medicines led by the chief pharmacists, work on information technology efficiencies led by the national information service and, finally, just a spread of work around shared services, which is led by the shared services committee. So, really, we've got some frameworks that we've now developed, and all of those will be evidenced in plans. And then through our various monitoring mechanisms, we just want to test that those are being delivered at pace. So, that's more about delivery and performance, but the plans should all now reflect those frameworks.

14:15

[24] On the other side, which I think is more the benefit of being in an integrated system, is what I would call 'allocative effectiveness'. So, how can we use the overall resource that we've got available to us to drive better outcomes for the population in Wales? There's a number of national strands of works around there. We've now signed a national agreement with the International Consortium for Health Outcomes Measurement. We're probably the first country internationally to do that as a country. Many parts of other healthcare systems have done that, and are measuring outcomes using the ICHOM framework. We are currently doing that for lung cancer and heart failure—

[25] **Nick Ramsay:** What is ICHOM?

[26] **Mr Brace:** International Consortium for Health Outcomes Measurement—an international organisation bringing together healthcare systems to more systematically measure outcomes on internationally validated outcome sets. So, this is something that I guess has been developed across all healthcare systems. We're a strategic partner of those; all of the boards have signed up to their work. We're doing the measurement, but we're also tracking the resources against those outcome measurement sets. And then individually, certain boards are progressing aspects of that type of approach. So, in Aneurin Bevan and Cwm Taf—they are now actually looking to save about £1 million in Aneurin Bevan health board by stopping prescribing for chronic obstructive pulmonary disease with the high-cost inhalers, and actually reinvesting about £0.25 million of that into pulmonary rehab and smoking cessation. The evidence says that, actually, investment in those areas drives better outcomes. Our spend tends to be the higher-cost interventions, so there's a recycling going on of resources: (a) to improve outcomes, but (b) to use resources better. So, we're progressing both those various strands at a national level now and, again, all of those will be featuring in people's plans, be they the three-year plans that we've got approved or the emerging annual plans for those in intervention.

[27] **Dr Goodall:** Two reflections on the efficiency board that I chair. I think it's helped us to land a level of expectation on compliance. You'll remember receiving the medicines management report here yourselves. Actually, there was one example in there about the use of biosimilars where we were able, through the chief medical officer writing out as a Welsh health circular, just to simply insist on the compliance with something that is in the best interests of patients, and for which there is an evidence base. I think that's

changed some of the approaches that we've had.

[28] Equally, we've received a number of reports through all sorts of different external sources, but if I was looking at some of the Wales Audit Office mechanisms, although we've advocated for people to review them seriously and to have local action plans on these as part of our process, I think we've helpfully been able to bring some of those in terms of efficiency opportunities into the efficiency board. So, it's no coincidence that therefore recently we've looked at operating theatres, we looked at the medicines management outcomes and we've looked at the elective waiting times report, because, again, I think it's an opportunity for us to demonstrate that we can do better. So, we're actually able to use those as a vehicle, I think, for some of the PAC and Wales Audit Office recommendations where they're helpful to the service.

[29] **Nick Ramsay**: And just before I bring some other Members in, when does the Welsh Government expect to be in a position to set revenue budgets over a longer period?

[30] **Dr Goodall**: From a group perspective, we've been given some indications of what we should work within, which haven't been too far off the reality when they've been provided over the years. It may be it's a broader discussion for Welsh Government and for Ministers to respond to, because, of course, the context here is being very reliant on what happens on a UK basis. And I think the fact that we've ended up with different approaches to the budgets recently—. There's been a much shorter term focus. Obviously, as we come into the next three-year planning cycle, we needed to be mindful that you have the end of an Assembly term. And then with a new Government forming, these are things that would have got in the way. But having said that, Alan, I think the indicative figures that were given to the NHS to at least prepare for—remembering that we have responded to the Nuffield and the Health Foundation areas—were actually there or thereabouts. They were pretty close to the original figures that were given by the service, so I don't think we've fallen short on those expectations with the NHS. And certainly, from a planning perspective, they've had, I think, much greater certainty than in the past.

[31] **Nick Ramsay**: Great. Mohammad Asghar.

[32] **Mohammad Asghar**: Thank you very much, Chair, and good afternoon both of you. Thanks to the NHS—I've got great faith in it—but in the last

three years I think there has been a deficit of over £250 million in the NHS budget, which is concerning. That's what my questions are going to be about. The Welsh Government does not announce revenue spending on NHS bodies for future years, which inhibits their ability to plan their duties and prepare any projects and improvement effectively. What do you think that the Welsh Government could be doing to support the capacity of the NHS in future?

[33] **Dr Goodall:** I think there are a number of different ways for supporting the capacity. So, irrespective of the budget-setting process that's in place, we are very reliant on individual organisations having the expertise and the experience to produce plans that we think are sound. Just to reassure Members around the table, what we have done within our process is actually maintained a high standard of expectation that these plans are able to be put in place, that people can demonstrate improvement, but actually they also show that they are able to manage within the resources.

[34] You may want to revisit this, but this, in part, was why, a couple of our organisations, although they had been placed with approval in the first place, unfortunately, in a subsequent year, because we didn't have confidence in their approach, we actually ended up removing their approval status, for example. But I think, from a system perspective, we've had to focus on a couple of different areas. The one that I'll touch on is actually about planning support, and Alan maybe wants to pick up on some of the financial support issues.

[35] Firstly, to make sure that we do have the skills in our planning system, for example, since 2014, there have been biannual events, where we gather all of the planning teams across the whole of Wales. I attend them personally, to give people a sense of my own expectations. We're looking at developing their competencies and skillsets, trying to bring in what is perceived to be best practice. We've been reviewing and wish to commit to a diploma on the planning side as well, just to show that there's a level of accreditation, given that the plans are such a fundamental part of the way in which the three-year planning system works.

[36] We put a lot of emphasis on our escalation status. So, although the legislation works on its own on the one hand and we review organisations, I think, usefully, at the same time—and again this was from a Public Accounts Committee recommendation—the NHS in Wales actually put in an escalation framework. So, I think, where we see organisations struggling, it does allow

us to come in alongside them and have confidence in those that we think can push further and go forward and have their ambition realised. But, clearly, for organisations at the high level of the escalation, whether that's, ultimately, special measures or targeted intervention, that does allow us to wrap particular support based on their individual needs. I would say that the reasons that organisations are struggling to have their plans approved, or indeed are at a higher escalation, is probably for different reasons, but the main driver is us having a confidence that they have a real clarity about their expectations and what they can do over the next three years—so, it is the planning mechanism. But I know, on the financial side, over the last three or four years, similarly, we've been building up the premise of needing to train finance individuals and professionals in different ways to have a much broader look, working on areas like value, which Alan was just outlining in one of his responses before, and, actually, a lot of work over the last couple of years on the NHS Wales Finance Academy, Alan, to try to bring finance professionals up to speed.

[37] **Mr Brace:** Yes. Just to touch on developing the finance function, I guess, because, for a number of decades, we were running a market-driven system, which was about commissioning and providing and, to some extent, using very particular finance approaches to work within that system, since 2009, it's actually a very different system that is more about population-health focus as well as a whole management and delivery of hospital and community services.

[38] So, three to four years ago, we set up the finance academy. I chair it as head of profession for finance in Wales, and there are almost four key pieces of work around that: one is just developing people, and there's a lot of work going on around our talent pipeline and developing our core competence. There's a lot of work on what we call 'core excellence', which is the tools, techniques, approaches we use to financial management and planning, a lot of work in the area of partnerships, and that's really to try and take advantage of the fact that Wales is relatively small and we've got the opportunity to work together. So, we work, for example, with the Wales Audit Office. Some of their staff come and actually work within health boards. We're trying to encourage health boards to go and work elsewhere so that they actually start to see some of the broader opportunities across public services in Wales.

[39] Then the final area of work is in innovation and adding value. We've got university health boards. We've got some really strong universities in

Wales that do some really good things around health economics. Cardiff Business School is a very well regarded business school, so we're starting to look at how we can take advantage of the in-university health boards and start to think about researching new techniques and new approaches for the future, because I guess we all say that we're in unprecedented times, but we don't really develop people to work in that type of innovative, forward-looking research-based way, and that's a growing part of the work, I think. And, as Andrew said, quite linked to that is this notion of value-based healthcare. How can we understand value from the point of view of outcomes that matter to people and then make sure we use resources to drive the best outcomes we can, which is very different from the normal sort of finance approach around basic efficiency? And I think our system allows for that; we can move money across our services, but we've got to get comfortable with the tools, techniques, and frameworks to do that.

[40] **Mohammad Asghar:** Thank you very much for that answer, but the fact is that value can be judged by the satisfaction of the public.

[41] **Nick Ramsay:** Oscar, just before you continue—. Did you have a brief supplementary on this exact point?

[42] **Rhianon Passmore:** Just briefly, in terms of the escalation intervention process, which was a recommendation, I believe, of this committee, how do you perceive that to be working? Because there are those who will say it's not working because there are some in special measures, and some will say it is working because it's been identified and therefore it's being targeted. Is it robust in itself?

[43] **Dr Goodall:** My view very much fits with the latter. I think the danger is that, perhaps in previous times, this wouldn't have been explicit maybe in the way that it is, and I think that the fact is that, through using the legislation, and approval or non-approval, and also through using the escalation, I think that we are calling out our expectations for individual organisations. It's a difficult thing to get approval in the first place for an organisation, and it's something that we need to have a confidence in, but it's certainly something to remove an approval label, which we've done for two organisations. So—

[44] **Rhianon Passmore:** But, to answer my question, is it fit for purpose in itself as a very important quality assurance?

[45] **Dr Goodall:** I think the escalation framework is fit for purpose. I think we have to learn and adapt to it as we manoeuvre through. Obviously, we sit around tables for discussions on organisations, both with auditors and with regulators, so I think we've had to learn on the first use of this for the first time. But, if there is an escalation framework in place in Wales, it needs to be used, and I think we have been using it, and that's why we have one organisation that is in the worst category of special measures, albeit with stabilisation around it, and it's why three others are in targeted intervention.

[46] However, I'd also say it's a good sign that we actually have organisations predominantly in routine monitoring. I think the organisation that has most demonstrated what you can do with an escalation is the way in which the Welsh ambulance service trust has improved over the last three years, has been able to reduce our concerns about it, manage within the money, produce a very clear plan, get approval status for the first time, and actually demonstrate that it's leading some of its performance, not least in Wales, but actually in the UK.

[47] **Nick Ramsay:** Great. Back to Mohammad Asghar.

[48] **Mohammad Asghar:** Thank you, Chair. Following the statement provided by the Welsh Government reiterating that they were not going to bail out health boards that are in severe deficit in this financial year, how would you envisage them balancing their budget without cutting services or projects in health boards in Wales?

[49] **Dr Goodall:** I'll start the response, but, again, it may be helpful for Alan to articulate the difference. You know, we have to—and particularly with organisations where we bring in the intelligence that we have through the escalation process, I think we have a responsibility on the one hand to be really clear that there is a statutory financial duty that organisations need to operate within. But, at the same time, I think that, if Welsh Government ended up expecting that, overnight, the budgets completely changed, there would be real dangers, actually, for access to services and some of the quality that is provided. And I think that even, if you like, in the harshest example that we've been pursuing, with Betsi Cadwaladr in north Wales, irrespective of our general views about whether the allocation is sufficient or not, the kind of comparison in place, and that we probably think that there are some genuine opportunities, our approach to that organisation has been first of all to stop financial deterioration, secondly to expect that there needs to be improvement, and then, thirdly, to push them towards the break-even

over time. Because we were worried that it would perhaps have an adverse impact on the local population or on some of the services. So, it has to be quite a considered approach, because, at the end of the day, it's still the individual organisations that remain responsible, but we do want them to make the right kinds of decisions going forward. I think that's why our expectations are to make sure that—. What hasn't happened here is that organisations have simply been pushed over the line by having the money allocated to them individually, and the reason that I'll suggest that Alan responds is that I think this is where the overall budget that is overseen by Ministers comes in, rather than just simply the NHS Wales budget. Our choice on these organisations—and I think it is a choice—is that it will be that there has been sufficient funding in the overall budget, as overseen by Ministers. We have needed to focus on these individual organisations, because, actually, we think they can do better at their budget management process. So, I just wonder if it's worth bringing forward Alan about the MEG budget and its distinction with the NHS budget.

14:30

[50] **Mr Brace:** Yes, and also just to say a bit more specifically, sort of just following up on Andrew's point, is that it's quite important to distinguish where each of these organisations is. So, for example, ABM in the last seven years actually broke even for six out of those seven. They've hit difficulties; I guess that's why they're in intervention. So, there is something. That is an organisation that has been more used to managing services and its workforce within its resources. Equally, Betsi Cadwaladr health board, over the last seven years, broke even four out of the seven. It's only in the last three years they haven't and there are very specific issues there. Whereas you contrast that with somebody like Hywel Dda, which has probably struggled since the board was created in 2009. So, it's quite important, in terms of the ability of these organisations to get back to a sustainable position, and then for us to judge when we think that they are capable of managing within their resources, and any decisions that we would want to make around repaying deficits or the support around that.

[51] Back to Andrew's point, though, I guess one of the things that we made a deliberate decision on is not to allocate money to create an artificial position at the year-end in any of these boards. So, we did get an in-year allocation of £68 million to cover the deficits in Betsi Cadwaladr and Hywel Dda. We made a deliberate decision not to allocate that, because it was quite important that that was very visible to the board and the actions that were

going to be in place to recover that were equally as visible. At times, in-year allocations can mask some of that by actually perhaps giving a slightly deflated artificial outturn. So, most of the interventions now have been focused around clarity on the size of the problem and then clarity on the actions to recover those positions.

[52] **Nick Ramsay:** Rhianon Passmore, supplementary.

[53] **Rhianon Passmore:** In regard to the £88 million over, I believe, the three-year period for Hywel Dda, is there concern that there needs to be a greater direction and clarity from Welsh Government in regard to how, when you've got that hole, you are then going to fill that hole in without causing the knock-on effect to local services? Is there a need for greater clarity on that, or do we just say, 'There you go'?

[54] **Dr Goodall:** Again, I'll start, and, if I focus on the plan, I think it may be worth Alan just updating colleagues on a process in place around zero-based budgeting for Hywel Dda, because I think that'll help some of perhaps their more historical pressures and areas that they've outlined. But, no, we can't just allow these things to drift. The escalation process, as well as our overall planning approaches, brings us into very close contact, as you would expect, with these organisations at various stages—it can be daily and weekly contact that's happening as we set out our expectations.

[55] Certainly, for Hywel Dda, they are missing an overall integrated plan that sets out their range of services, right through from primary care through to the hospital services. I've been pleased to see that, over this last two or three weeks, actually, they have gone into a public environment with a couple of key areas, which I think is important for them for the future. One is the process that they want to take forward around discussing their clinical services and their sustainability for the future. That's led by the medical director and it's with community health council support. And they will be using the next weeks and months to have a much broader discussion with the public about the nature of their local services.

[56] But also, in quite a traditionally tricky area, they've been able to now develop and sign off a plan for mental health services for the whole of the patch, which, again, is sometimes forgotten perhaps to the side of organisations, but is a really important thing that they're taking forward. We have set a clear expectation for them to step up into that arena, that they must have these plans and that we would have an expectation that they

discharge it through better public engagement.

[57] But I think there's an outstanding question with Hywel Dda, as an example organisation, which is that people will query whether the resource allocation is right or not for a population base that is more rural, with the spread of hospitals that they have in place, and given some of the issues that they've been trying to deal with over the years. And that's why, with the agreement of both the Cabinet Secretary for finance, and also for health, well-being and sport, we have agreed to do a zero-based budgeting exercise, which helps to answer these questions. I think, Chair, it's probably just worth quickly pausing on those, because I think that will give you some reassurance—Alan.

[58] **Mr Brace:** Yes, as Andrew said, if you look at our needs-based formula, which we use to allocate resources to boards, Hywel Dda would be above the formula share. So, in terms of our formula allocation, they are probably slightly over funded, and yet they are struggling to deliver in terms of—well, since 2009, they've struggled to live within those resources.

[59] So, what we've done, as Andrew said, is commissioned a bit of work that is looking at four things: the demographics of the population, they're looking at aspects of remoteness and rurality and how that impacts on spend and delivering your services there, also looking at scale—I think one of the questions around Hywel Dda is that they run four smaller-type district general hospitals than perhaps you would see in urban areas—and then the fourth element, which is quite important, is their opportunity to deliver greater efficiencies even within that configuration.

[60] So, we're about to see the draft report, which will actually pick up their findings across those four areas. We'll use that to help us inform, then, perhaps some of our work that we need to do on our own resource-allocation formula, as well as having a look at what that would mean in terms of funding for Hywel Dda as a board.

[61] **Neil Hamilton:** Can I just ask a question—

[62] **Nick Ramsay:** Neil Hamilton.

[63] **Neil Hamilton:**—on that? In relation to Hywel Dda, we've now had eight years' experience of this board, and there are continuing and, indeed, increasing problems in certain areas of clinical activity, particularly in

Pembrokeshire, as you know; there have been significant problems, both with paediatrics and with maternity. Given the distances that people now have to travel to be served, there's a significant shortfall in service provision, in effect. I mean, eight years is quite a long time to have to readjust your priorities, whatever the circumstances about the initial funding position. When is this zero-based budgeting report going to be on your desk?

[64] **Dr Goodall**: We're expecting the report imminently to sign off, and I think it will be over the course of these next few weeks that we'll have a chance not just to understand that ourselves, but actually, most importantly, to make sure that we have an understanding in respect of what Hywel Dda can genuinely do. And when you talk about the eight-year period, we do approach our discussions with Hywel Dda recognising that, again, irrespective of the fact that clearly the statutory duties apply to all individual organisations, there's always been, if you like, a historical component with Hywel Dda. And for any new team arriving, irrespective of their competence, to find a way of saving some of these funds in a year, within two years or three years has been quite difficult. We have a different sense, though, with the organisation.

[65] Again, under the targeted intervention mechanisms and particularly over these last six to nine months, I have to say I saw, irrespective of some of the budgetary issues—if I can just park them—a much stronger focus from the organisation around delivery. So, if you look at Hywel Dda as an organisation, actually it's been more leading in some of its performance targets and responses than some of the other health boards in Wales, even on areas like cancer where, actually, it's one of the two leading health boards in Wales, on the available figures. But we've also seen some of the trickier services that have required support, for example, from locum staff coming in from outside—Withybush hospital in particular—where people are choosing, actually, to want to stay to work as a substantive employee within Hywel Dda, which I think is also a good sign. So, from my own personal perspective, if we can simply get them to articulate the plan on a more public basis, to get some broader ownership, to make sure that's done through a clinical perspective, I think they could find themselves in a much better position, and I think the zero-based budgeting process just simply helps us to deal with the equation around the money and the funding in a bit of a different way. So, actually, I would say that I've seen some good progress from them as an organisation, even though it's felt like it's been a long time and, to be fair, under different administrations, so probably the best sign of progress over the last 12 months.

[66] **Nick Ramsay**: Okay, briefly Rhianon Passmore before I bring in Vikki Howells.

[67] **Rhianon Passmore**: In terms of my question, which was more around whether there is a need for Welsh Government to be clear and concise in terms of where there are such deficits historically—and obviously there are intractable problems in some—is there a need, in your mind, for there to be more ability to be able to direct health boards from Welsh Government?

[68] **Dr Goodall**: Well, there are direct mechanisms in place already—so, appointment processes. I technically delegate out responsibilities from myself through an accountable officer letter to the individual health boards as well, to their chief executives and to the trusts. So, there are mechanisms in place. I think that we have made choices about direction and accountability in a different way over the last two years in particular that I think are translating into some of the issues that are fed into this report, but also in terms of our broader performance.

[69] I think the area that is more difficult for us to, perhaps, progress as we would see fit is that the legislation puts in place a responsibility for the health boards to discharge plans for their local communities, and that includes service change. So, Welsh Government's role there is, if you like, to give the framework to authorise the kind of changes that are going to now make an impact on patient outcomes, but it is for the health boards to step up in there.

[70] **Rhianon Passmore**: I accept that, but where you have intractable problems that don't seem to be—in some areas, granted—being resolved, surely there needs to be another lever at your disposal?

[71] **Dr Goodall**: Indeed, and we are doing more of that. A recent development at the request of the Cabinet Secretary has been the establishment of regional committees that act as sub-committees of the boards. They previously would have been committees that act only in support of the individual organisations. We've had the first of these just over the last two or three months or so, and I actually attend these committees myself in order to bring part of my NHS chief executive role to the table, to add more direction. But I think even where we are signing off organisations' individual plans that would constitute some of the service changes that would be expected, we also bring with it an expectation that those organisations will

engage in the right manner with their communities and make it happen.

[72] But I can absolutely say that, for some of the regional expectations that we have—that might be commissioning centres of excellence for elective centres, allowing us to access some of the capital money—I think we'll be much clearer now about our expectations through those types of processes. But, accountability and this delivery expectation has not always been there, and I do think we've used the legislation and the escalation to make that much more visible.

[73] **Nick Ramsay**: Okay. Moving on to oversight and accountability, and, Vikki Howells.

[74] **Vikki Howells**: Thank you, Chair. The ability to plan in the medium and long term financially is something that you've alluded to, both of you, so far. But surely the duty to offset unplanned overspends in previous years against that creates something of a barrier. So, my question is: would you accept that it would be helpful for Welsh Government planning guidelines to more clearly set out how it expects NHS bodies to balance the duty of forward-looking, three-year plans against the duty to offset unplanned overspends from previous years?

[75] **Dr Goodall**: I mean, briefly, from myself, I would say on the one hand, we do give clarity. We've got a planning framework in place for the next three years—always in place. We're very happy that committee members see a copy of this just to get some reassurance as to the kind of level of detail. But I think, probably, that's a technical issue of the financial side. I'll ask Alan to give the personal perspective on that.

[76] **Mr Brace**: Yes. I mean, we're only dealing with 10 organisations, seven of those as local health boards. So, I think, through our guidance, through our regular monitoring, through our conversations, through our monthly meetings, we're really clear. I think some organisations are struggling. Six out of 10 organisations are capable of doing it, and they demonstrated that they can do it. So, I'm not particularly—. Certainly, when I was in Aneurin Bevan health board, there wasn't a lack of clarity. I didn't need more guidance from Welsh Government. I think these are difficult things, and you're constantly meeting the needs of your population, developing services and delivering on performance. Delivering on money is a complex task and something that is fairly constant, but it wasn't an issue of guidance. There was no more guidance that was required, I don't think.

[77] **Vikki Howells:** Okay, thank you. Moving on then to performance and the improvement in performance that's been alluded to in the Welsh Government reports. Do you attribute that to the approach to performance management or to the increase in funding that's also referred to in the report?

[78] **Dr Goodall:** I think one doesn't come without the other. I think I said earlier that my view was that, whilst the legislation's in place and sets out how you legally comply, actually the methodology that we've employed and our choice, if you like, to change some of the traditional culture of the NHS has been quite important. I think that would actually apply to the performance arena as well. Certainly in discharging my own role alongside colleagues like Alan, with Simon as the deputy chief executive of NHS Wales, we have chosen to ensure that there is a clear focus around performance and on a wide range of fronts, although there are always some higher profile targets than others. I think that, as we look back to the end of 2016-17—to March 2017—we've actually seen a number of our performance measures get in the best position that they have been for some time. So, on some of the visible areas, like diagnostics, the best since March 2011, and on areas like our referral to treatment waiting times, it's our best since March 2014. We've seen the ambulance service performance improve. But although there are some very dominant areas—you know, on our A&E performance, we've managed to show improvement from last year, just to show some sustainable approach has been taken. It's been also important to demonstrate progress on other measures, like quality. So, we've also seen our infection rates continue to reduce, which has been a pattern over the last five years or so, as a quality challenge in there.

[79] But it is quite clear that we've had a benefit from some of the additional funding that was allocated, which was simply there for performance purposes. So, when we look at diagnostics and referral-to-treatment time, clearly, there's been a benefit of some of the in-year funding that was provided for those two areas over the course of these last two years, and that has contributed. But the bit I'm describing is that, actually, on our performance approach, we've seen more rounded performance than just that, kind of, single issue, and I do think that that has allowed us to make sure that we've landed a better position. But if you only put in the money with an expectation and you don't have a mechanism for tracking or for monitoring the services, then don't be surprised that the NHS isn't necessarily always demonstrating what you want. I think we've been much

better on the discipline.

[80] **Vikki Howells**: Finally, then, is the Welsh Government—

[81] **Neil McEvoy**: Just before we move on—

[82] **Nick Ramsay**: Hang on. A supplementary on this point exactly?

[83] **Neil McEvoy**: Yes, it is. I think some politicians do like a lack of accountability. Just on one of the statements you made there, about the ambulance service improving, to my information, you changed the criteria as to how it's judged. So, really, you've made that statement, but we can no longer compare like with like. Would that be the case?

14:45

[84] **Dr Goodall**: It's not a direct comparison, but there is a more direct comparison around the red responses in particular, which allows you to be more traditional and, to be fair, the ambulance services across the UK have wanted to learn about the examples going on in Wales. So, there's been some reflection from the Scottish ambulance service. We are now seeing a number of the regions in England actually going with a similar mechanism. I think, rather than changing it, our choice actually on this was to want to understand from a clinical perspective what the ambulance service was responding to, to allow a discussion that was driven by paramedics in terms of their responses, to put a real focus on the life-threatening nature of the calls that they need to respond to and, as well as changing some of the categories, also ensure that we are better able to get better responses to some of the other amber categories.

[85] I think the change we introduced was a real focus around putting into the public domain a focus around quality measures and outcomes that will demonstrate whether it makes a difference to the individuals who are being responded to by the ambulance service. I don't want to give a direct comparison on the measures, as you've said, but there are some ways that you can measure it. But I can say that the ambulance service performance in Wales is actually standing out on a UK basis at the moment, not on the strict comparison but because people are interested in the methodology, and it is being discussed in professional quarters.

[86] **Neil McEvoy**: Okay, but the fact of the matter is that, because of the

changes, we are no longer able to compare like with like. If you do speak to some medical staff that I speak to and who make a point of speaking to me, then they would actually maybe dispute some of what you're saying.

[87] **Neil Hamilton**: Can I supplement that with—

[88] **Nick Ramsay**: Hang on a minute, because we're getting a little bit off the mark here—

[89] **Neil McEvoy**: Yes, I just wanted to point that out—that the criteria have changed.

[90] **Nick Ramsay**: I want Vikki to finish her questions and then I'll bring both of you back in. Okay, Vikki, back to you.

[91] **Vikki Howells**: Thank you, Chair. With regard to the parliamentary review of health and care, is the Welsh Government confident that it will deliver a clear vision and direction for services as expected?

[92] **Dr Goodall**: It seems to me that there's a genuine intention and the cross-party support to allow the review to be established. I think that's been really important here. We have experts with international and UK experience to comment on Wales, which I think really helps us in a different way. I think that, probably, rather than comment at this stage, Chair, I'm aware that the Cabinet Secretary will be making an announcement about the interim findings of the parliamentary review tomorrow, and that will give Members greater detail on where we are. But, certainly, the final report isn't going to be out until the autumn period at this stage. I think it will help us to have a clearer set of recommendations through an expert group, but the real clear need will be to make sure that the revised and refreshed NHS strategy for the future—and I would actually say a strategy for our care system in Wales—will be the important aspect, to make sure that Welsh Government and Ministers can respond to that in that way. And that will be in response to the parliamentary review.

[93] **Vikki Howells**: Thank you.

[94] **Nick Ramsay**: Okay. Right, back to the ambulance issue—. Oscar, hang on. Neil Hamilton.

[95] **Neil Hamilton**: It seems to me, listening to the exchange between Mr

McEvoy and you in relation to the ambulance service trust that we're moving away from performance measures that we can understand into the sort of anecdotal area of judging performance, which is clearly sub-optimal, shall we say? Given that red response times are only about 4 per cent, if I remember correctly, of the total calls, we're giving—. Obviously, the more life-threatening calls are what we really want the ambulance service for because they have to respond within a few minutes, but, nevertheless, considering the performance of the trust as a whole in this area, concentration upon what's a very small proportion of the total perhaps might distort the actual effectiveness with which the services are being provided.

[96] **Dr Goodall:** And I would say that that's absolutely why, as we've produced information, we've not allowed it to be simply about the time bands and the comparisons. It's absolutely true that we had to change the focus of the service, because this was redesigning the system. It wasn't just the performance monitoring aspects. So, we have changed the focus, ranging from the triage mechanisms that are in place initially to demonstrate that we can signpost people to other services—. There's a hear-and-treat service that's in place as part of this change. But I think that, rather than suppressing information, the suite of information that we produce around the quality measures is much in advance of what was available before, not least in the public domain.

[97] Chair, if it helps, I'm really happy to demonstrate the information, the evidence, that's available to Members about the changes that we put in that were an alteration in the ambulance service. We have very strong views from clinicians involved in this about this having been a good outcome. I think the fact that we are also seeing better recruitment of paramedics across Wales—a real interest in being part of the ambulance service—. We're seeing them delivering in other ways beyond just the response targets as well. This is an organisation that's got a real clarity about its future, and I have to say that that's why we looked at de-escalation within our escalation mechanisms. I don't know whether a note may help just to articulate this and actually maybe give some of the links that show how much of this is in the public domain.

[98] **Nick Ramsay:** If you could provide us some more information on that that would be very helpful to the committee.

[99] **Dr Goodall:** Of course.

[100] **Nick Ramsay:** Yes. Okay. Neil, had you finished?

[101] **Neil McEvoy:** Yes.

[102] **Nick Ramsay:** Oscar—Mohammad Asghar.

[103] **Mohammad Asghar:** Thank you, Chair. Well, the thing is, I'm not asking about ambulance or cancer drugs or anything—what strategies are in place to monitor the performance of health boards that are not financially sound at the beginning of the year but whose plans are, nevertheless, approved by the Welsh Government?

[104] **Dr Goodall:** Again, I'll start generally, but Alan may help with some of the technical mechanisms that we've put in place. I think we take cognisance of a lot of issues. We don't simply just take the plan in complete isolation. So, for example, the financial track record of organisations will be quite important in terms of: have they got there before and have they managed within their resources? Although I'm now three years into my national role, I was a health board chief executive myself, as you know, for five years, and, actually, I'm not sure that any individual year we started the year having pinned down absolutely every component of the finances. These are organisations of scale, and to feel that you start on 1 April with every nuance of the finances all in order would be misleading, I think, to say.

[105] You do have confidence about knowing what you've done before, of the different areas that you're looking for improvement in, and actually that it's possible to demonstrate that the quality focus of an organisation makes a difference on the finances, but we are reliant on the regular monitoring. So, I know: I used to report in—now, I receive them instead—and I used to outline the risks that we were managing, but I also used to outline very clearly the actions that were being taken forward by the organisation. But the way we manage this is by trying to just bring other intelligence to bear. So, Alan may want to outline some of the mechanisms, but when we decided that Abertawe Bro Morgannwg University Local Health Board and Cardiff and Vale University Local Health Board needed to be non-approved, some of that was because although they were stating the right kind of intent, on our own figures we could see actually that their finances seemed to be a growing and much greater issue of concern. And I think it was our central monitoring that meant that we were unhappy as part of the additional information that was used.

[106] **Mr Brace:** Yes, and just to add to that, I guess, on the finance side, there's a whole raft of mechanisms, I guess, from the very detailed monitoring that boards send in to us every month. I meet all of the finance directors monthly and, clearly, that's an opportunity to discuss issues that are sort of broadly affecting everybody. We have sort of joint executive team meetings four times a year where the Welsh Government executive team will meet with board executive teams. So, there are a lot of process and frameworks around monitoring performance.

[107] I guess I'll pick up on Andrew's example. I think probably an area where the Welsh Government stepped in was ABM. In 2015-16, ABM, who had been delivering successfully financially mid-year started to forecast a pressure of about £28 million. They recovered that non-recurrently, but through all of this monitoring and these various mechanisms, there were enough warning signs that they were getting themselves into difficulty recurrently. I think when they then produced a plan and sent it in, they were actually looking for approval and, I guess, an endorsement that, as a team, they could probably deal with that level of risk. Through all of that intelligence process sort of monitoring, I think Welsh Government felt they couldn't, and then that led to the refusal of the plan and targeted intervention. From the experience of targeted intervention, that probably was the right thing to do for the organisation.

[108] **Nick Ramsay:** Okay. Neil McEvoy.

[109] **Neil McEvoy:** Thanks, Chair. I just wonder why it has taken until now to recognise and address the gaps in NHS bodies' capacity to plan, given that the system based on planning has been in place since 2009, with the reforms creating the integrated health boards, which were supposed to strengthen planning.

[110] **Dr Goodall:** I think we've remained true to that planning approach, and, obviously, the system needed to adapt. I think there are many opportunities about the way in which you gather services, right across from primary care and those settings through to the hospital environment. I think, as I was outlining before, there are a number of steps that we've taken, and certainly from 2014, and as I've arrived, the approach of bringing a planning network together—so it's not just what we've done in the last few weeks; it's actually what we've been doing over the last three years—it's particularly important to recognise that there's a lot of shared learning. I'd also emphasise that, as we started off in the first year, there were only four of our

plans across Wales that were approved out of the 10. We moved that to seven in the second year. That dropped down to six the year after, not least because of the implications of Cardiff and ABMU as well. I do think that the successful organisations, which are showing that they can plan properly, that they're able to respond and deliver on the ground do demonstrate a lot of the characteristics that we're looking for.

[111] But as I outlined earlier, I try to be very clear on our expectations. I think, as reflected in the report, our planning framework guidance has improved. There are those who want more detail to be available, there are others who feel that they'd like less—we try and call it in the middle, and we certainly have learnt and adapted on that process. But I like the idea of the accreditation of planners to really demonstrate that they're not just interested individuals, they've got the proper skill set, so this concept of the diploma is pretty important, I think, for us to push forward and make happen.

[112] **Neil McEvoy:** That was my next question, actually. But I accept what you're saying about 2014—what you've done there with the planning network. What was happening from 2009 until 2014, then? Was progress made over those five years?

[113] **Dr Goodall:** I think organisations were learning. It was a very significant change to organisations back in 2009. I was one of the original health board chief executives and we were creating organisations from what, at one point, had been 37 different health organisations across Wales, and reflecting a system that got this down to 10. So, my own previous organisation was bringing five areas plus a trust organisation into one, so you're mixing six different organisations in there. I think, quite clearly, as part of the establishment of these organisations, although people kept a focus on delivery, it was necessary to ensure the team worked together, that it was clear for the future, and I think the plans were all part of that at that time. Remember that the legislation itself came, and that had been in response to criticisms that there had been back in 2013, and some previous committee reflections. I do think that the legislation and the guidance that ensued have really helped to lift our perspectives. These were new organisations having to put their own stamp and culture and leadership expectations, and were starting to have to demonstrate a delivery on behalf of their local populations pretty quickly. It was a difficult time to go through, but I maintain that I think the planning system approach that we've deployed actually has a lot of advantages to bring.

[114] **Neil McEvoy:** So, what you're saying, really, is then, the eight years was a sort of natural organic period of growth.

[115] **Dr Goodall:** Well, I think we've had to progress, and I think that's true in the way that we've tried to learn from the legislation and how we've implemented the escalation framework. I think you have to use it, you have to use it for the proper reasons, but you actually have to allow yourselves to learn and produce the right outcomes. Actually, from a legislative perspective, it would be very easy for us to produce a system where there are 10 approved plans and there are 10 organisations in balance. The fact that we've chosen not to discharge that because we feel those plans need to be clearer, because we don't feel that they've met the standards and we feel that we can organise the money in a better way is quite important.

[116] **Neil McEvoy:** Okay. Just to go back to what you touched on earlier, the postgraduate diploma in NHS planning—are there plans to extend that to a wide group of NHS staff?

[117] **Dr Goodall:** Yes, I think so. I think we can naturally try and bring together some of our resources, not least with some of the finance experiences that Alan was outlining. But, yes, I would have a real expectation that this planning mechanism becomes, if you like, an accredited part of our system. I think that, although people working in planning departments can be seen to the initial target audience, I think it's a much broader group of staff that we're looking to be part of this, and coincidentally, I'm actually talking and meeting with everybody on Wednesday this week, which is the latest planning network meeting, and I know that this will be one of the areas that they're looking to do. But, yes, from a central perspective, we will be making this happen. There is a lot of support and endorsement from the service, and we think this will put us in better stead for three years' time.

[118] **Neil McEvoy:** Just one final question, Chair. In terms of experience of management, which chairs of which boards had no experience in NHS management prior to being appointed? Are there many?

[119] **Dr Goodall:** It's not for me to necessarily comment on the chair appointment process, but, actually, we—

[120] **Neil McEvoy:** It's a factual question of whether or not they have experience with NHS management.

[121] **Dr Goodall:** I think the reflection on NHS management is a more important thing, clearly, for chief executives of health organisations to have exposure to than necessarily a requirement for chairs. So, in the public appointments process that is part of the chairs' placements at this stage, although we are looking for people who have a knowledge of the NHS in general terms, we're not specifically looking for people who have to bring NHS background skills.

[122] **Neil McEvoy:** I don't want to go into the appointments process, but maybe in writing could you confirm which Chairs of which NHS trusts didn't have any NHS management experience prior to being appointed? Because I think it is quite important, given it's taken eight years of organic growth to get where we are now—I'm not disputing that. I think it would be interesting for members of the committee to know which chairs had NHS experience and which ones didn't. It's a simple question—looking at their CV.

[123] **Dr Goodall:** I think, Chair, probably given that chairs are appointed by Ministers on the recommendations of public appointment, it's more appropriate to ask that question to Ministers rather than myself. What I would emphasise is that for executive teams and chief executives, quite clearly, there is a requirement for people to show that insight into the NHS side. I think chairs have a governance role to deploy in organisations that will give a different mix of skills, but it's not to say 'no' to it. I think if I could ask that we direct that through the Cabinet Secretary—that would probably be more appropriate, if that's okay.

15:00

[124] **Nick Ramsay:** Chief executives would have that information about the background of the chairs as well, wouldn't they?

[125] **Neil Hamilton:** It's all public information.

[126] **Dr Goodall:** It's public information. It's just I would suggest on this it feels appropriate—given that this is not about the executive function, it's about the chair mechanism, and they are appointed by the Cabinet Secretary.

[127] **Nick Ramsay:** Okay. We can direct that through the—

[128] **Neil McEvoy:** As long as we get the answer, I don't mind.

[129] **Dr Goodall**: I'm happy to facilitate that outside. I just feel it's a more appropriate question for a Minister.

[130] **Nick Ramsay**: I understand what you're saying. It isn't the chief executive role to do the actual—

[131] **Neil McEvoy**: The thing is that when you talk about how the NHS works, chairs do play a major role in making the whole system work, so I think it—

[132] **Nick Ramsay**: I think the point that Dr Goodall is making is that that is not really an issue for him in his role. That is an issue for, as you say, the Ministers who ultimately sign off the appointment of the chair, and would oversee the process of appointment—

[133] **Neil McEvoy**: Can we agree that we get that information, then, Chair?

[134] **Nick Ramsay**: We can discuss that afterwards. I'm sure we can do that. It's public information, as Neil Hamilton said.

[135] Okay, Rhianon Passmore on Welsh Government's review and approval of plans.

[136] **Rhianon Passmore**: Thank you, Chair. What, if any, other tools would enable you to have more or greater capacity to both review and challenge NHS plans?

[137] **Dr Goodall**: To start the response, I think we've learnt an awful lot about the process because Welsh Government's oversight changed as a result of the legislation. We didn't just simply carry on with more of the same. After we'd discharged the first year, we deliberately asked for an internal audit report to be done, actually, on the way we had approached it, and I think one of the concerns that we had was the danger of having a wide range of fragmented views on the plan. We've actually used the planning process to make sure that Welsh Government itself is able to bring in the different expertise, whether it's the mental health professionals, the nursing perspective or the chief medical officers' review, along with those who are involved in overseeing our unscheduled care system.

[138] The internal audit report we had back in 2015, actually, gave

substantial assurance in terms of what we'd learnt in year 1, but we have continued to adapt it for our second year. What I would say is that I think it's quite right that within our existing resources maintaining a real focus and oversight of the plans is well within our gift. I think it should simply be core business for the Welsh Government, oversight, and we should do it. The trickier issue is the extent to which organisations are struggling, and whether they're struggling because they need support on a plan, or whether it's because of the financial context or not delivering on performance, and the way in which we deploy the escalation framework so that, if organisations are in that, there's a higher degree of contact that takes place with them. So, I would discriminate—. I think the plans—I think we can discharge that within our existing approaches and mechanism and continue to learn. It's more about landing the support and challenge alongside the organisations, which is probably the real issue to address.

[139] **Rhianon Passmore:** So, in terms of answering the question, what I'm asking really is: do you feel that's satisfactory and robust in terms of that escalation process? Do you feel that there is a need—surely there must be optimum thinking around this—to be more rigorous in terms of that capacity, or are you satisfied that you have the tools that you need at your disposal?

[140] **Dr Goodall:** Alan.

[141] **Mr Brace:** Just to perhaps give a personal perspective from a finance point of view, I think it is now very different in terms of the six out of the 10 that are approved. I think to some extent that is a different support that is required from us, and that's more about, I guess, realising the service changes and managing the resources more in the medium term. For those in escalation, one of the early reflections coming into the role for me at the end of September was there were some fairly obvious things that needed addressing. Part of that led to the commissioning of the financial governance reviews, but it also led to the establishment, which we're in the process of getting together, of the finance delivery unit, which will be a unit that will work more directly to me to get a much more consistent and comprehensive approach to some of the basic things that we think need to be done in some of these boards. So, sharing learning, and getting that implemented and delivered at pace is probably where we're going to put some targeted resource now.

[142] **Rhianon Passmore:** Okay. So, that's in action at the moment.

[143] **Mr Brace:** Yes, it's in the process of just being established.

[144] **Dr Goodall:** And as organisations give us more assurance within any processes about their status we can step away a little bit more, but certainly the escalation bit is the bit we continue to scratch our head on and check. What I would say is that it does take a lot of my time and of Simon's in his deputy chief executive role for NHS Wales, and certainly Alan's, given that finances are quite a key part of these processes, but we also feel that we do get a return on that time and investment, and given that we talk very regularly to organisations, we've not had to invent a whole new series of processes. We've been able to use some of our traditional contacts as well.

[145] **Rhianon Passmore:** So, do you feel that you have enough people resource?

[146] **Dr Goodall:** I think we need to keep reflecting on whether we need more in the escalation space. I think we've managed over this time and we've learnt and adapted as we've pushed forward. I think we may need to look at some different ways of delivering more resources and capacity.

[147] **Rhianon Passmore:** Okay, thank you. Can you tell me concisely why you didn't approve Cardiff and Vale and ABM?

[148] **Dr Goodall:** I think, simply, with both organisations, mainly because we were unable to see—although they had strategic ambitions—a translating of, perhaps, a broader view of the world into clear milestones for the next three years. I have to say, to different degrees in the organisations, that we had a concern about performance. So, although Cardiff has much recovered its performance position, at the time when we didn't approve the plan, it was quite clear that they were going away from some of the performance delivery that we would expect on some of the measures and targets that are in place. That was absolutely true of ABMU in terms of the non-approval—that they'd gone astray. And, finally, just to say that the finances simply didn't add up—the prospective issue that they set out for the year ahead was unacceptable. Therefore, despite positive intentions the previous year from them and also from the Welsh Government, it was important not to skew the standards that we set on signing off the areas, and that's why we determined and gave advice to the Cabinet Secretary to not approve the plans.

[149] **Rhianon Passmore:** Thank you. Do you think that the new, stronger

approach on capital projects will encourage NHS bodies to be more strategic in changes for local services?

[150] **Mr Brace:** Yes, absolutely. I think where we are now is that a lot of emerging evidence, whether it's Clinical Futures and the specialist and critical care centre in Aneurin Bevan; or transforming cancer services, led by Velindre for the region; the ARCH programme between Hywel Dda and ABM to try and more jointly develop services and link that through to the city deal; the HEART programme in Cardiff—. So, increasingly now, we're seeing, across the system, much more of a focus on strategic service shift, rather than replacing buildings, although, in each of those schemes, buildings remain a key part of the infrastructure required to shift services in a different way for the future.

[151] **Rhianon Passmore:** Thank you. I've got another two questions that I wanted to place to you. We've spoken a lot about the escalation and intervention processes, and we've also mentioned that they've taken significant leadership capacity, sometimes, out of organisations. Do you feel that that's proportionate to the benefits?

[152] **Dr Goodall:** Yes, I think there's a return from it. I think, whether we're looking at improving the plans, or being clearer on the areas to balance support and challenge, there is a return on it. We don't quite get the return as quickly as we'd want on all occasions, but, certainly, I've been in contact with Betsi Cadwaladr through its special measures process—probably regular, weekly discussions and meetings, being physically up there every three or four weeks or so to deliberately meet with the teams up there. Although it's a time investment, I think the time gives us a return, ultimately, and a lot of this is about understanding the pressures of organisations, but also understanding we have responsibilities to support.

[153] **Rhianon Passmore:** With regard to the financial reviews that you've talked about, the Deloitte—I don't know whether you'd classify it as a review or research—I'd like to have a little bit more information about that. But do you feel that you are in a position yet to be able to share any of the emergent messages from these?

[154] **Mr Brace:** They were formal reviews that we put out to tender, with some very specific objectives for those reviews. We're hoping to clear the reports this week. Just to give you a flavour, the areas they covered are: board monitoring assurance and approval mechanisms, so how the board

has operated in a financial governance sense; the management processes that have supported the boards in that regard; and then the third element is performance management and reporting. So, they found that there are areas that need developing, and I'm sure they'll—they're helpful for us in the sense that we can reflect more broadly across the system in terms of development needs and learning. But, very specifically, I think they'll help the three boards that were involved in the reviews.

[155] **Rhianon Passmore:** So, obviously, they're separate things. In terms of an overarching impact from, for instance, the Deloitte research, is there anything particularly that you can outline as to what that difference is going to make to our health boards?

[156] **Dr Goodall:** I think there is broader learning about what we need to do next, so I'm quite keen to make sure that, irrespective of what we have set out for the three individual organisations, firstly, it simply starts with the boards having to recognise what this means for their own governance, because a lot of our focus is about trying to get the organisations organised and focused on the right kinds of issues. The second bit is to make sure that these aren't just individual reviews left with the organisations. Certainly, I think there is the potential, as we receive the final versions of these and are sharing them with the organisations, probably, to look at what are the characteristics of organisations that have been successful, to share, as much as those organisations that are struggling. I'd really like to make sure that there's a positive aspect about what we focus on here. So, we can learn from those that are struggling, but I still think there's something outstanding about learning from those organisations that have managed to get their—the six out of 10 organisations, as well. But we'll be pushing the reports out to the boards to discharge through their governance aspects, and with a clear expectation of these issues of course being handled in a proper process within the public domain.

[157] **Rhianon Passmore:** Okay. Thank you. And finally, in terms of financial governance reviews, will you consider the extent to which NHS board members are involved in developing and owning the three-year plans?

[158] **Mr Brace:** Yes. That was a very specific part of the review, just that whole board process. And I think they did find issues for development on how the board effectively discharged that requirement, and that's the independent members as well as the exec. So, there will be some very specific recommendations about exactly that.

[159] **Rhianon Passmore:** Okay.

[160] **Dr Goodall:** And there's also complementary information that we're able to use, albeit shared through the boards themselves, the structured assessment work that the Wales Audit Office does—all of this is really helpful intelligence about, sometimes, observation of what boards are up to, rather than just holding them to account. So, we need to draw all of that information together.

[161] **Nick Ramsay:** Just before I bring Neil Hamilton in, in the case of approving a plan that contains potentially controversial service changes—and we can think of examples of that—is the Welsh Government committed to supporting those changes even if there is significant local opposition?

[162] **Dr Goodall:** Well, the legislation focuses on the health boards needing to declare their own plan. So, as we approve the plans for organisations, we're indicating that we accept that there are areas that they need to go at, to highlight. There are decisions about sustainable services that they need to take forward. The bit that we stand away from to some extent is we have an expectation that that is discharged clearly through the proper engagement mechanisms, on a public basis, and through their local arrangements. So, although we approve the plans, there inevitably are some conditional elements about that approval. And if we made it too pure, the danger is we'll never have any organisation in Wales ever able to sign off any kind of plans. But I have confidence again, mainly driven by the organisations that have managed to get there and go there, that they can be endorsed to have their plan, but they can still make a successful service change happen. So, I'm mindful of some of the recent discussions and changes that happened in both Cwm Taf and Aneurin Bevan health boards around stroke configuration. They've been able to land a much more appropriate local discussion, I think, than Welsh Government driving those. They engaged locally, ultimately ended up with a service that is demonstrating really good and excellent outcomes that are in line with what our central expectations would be. I think there are, however, some areas that have come through perhaps more of a regional lens, and I think probably they're the areas that we need to more focus on in terms of ensuring that they are made to happen across the different boundaries.

[163] That's why, to some extent, seeing organisations like Hywel Dda and ABMU step up into agreeing that they're going to have more of a joint

strategy for the future, which is encapsulated by their ARCH programme, demonstrates that organisations are starting to now properly look over and above their own individual organisational boundaries.

[164] **Nick Ramsay:** Okay. Neil Hamilton.

[165] **Neil Hamilton:** The 2014 NHS Finance (Wales) Act was supposed to lead to more strategic thinking, as we've been discussing, and a move away from short-term focus. Looking at the evidence, at least that which is supplied through the auditor general's report, experience is patchy. We're now in the second year of the application of this Act. How far would you be able to say that the behaviour of NHS bodies, and the Welsh Government itself, indeed, has responded to the obligations set by the Act?

[166] **Dr Goodall:** Well, I think six out of 10 organisations have demonstrated that they can meet the Act's expectations. So, firstly, I think we need to take some comfort from that—that we're able, even by having high standards being applied in criteria, to manoeuvre it through. I think, actually, the discussion we're having here around the table, for me personally, having sat here a number of times before, probably feels a little bit different in areas, because we're starting to describe examples of more strategic change breaking through into our system, like the specialist critical care centre agreement, the transforming cancer services approach, the heart arrangements in place in Cardiff, and ARCH. We need to ensure that Betsi's able to pursue its clinical service strategy.

[167] And I would suggest that, as we started the implementation of the Act—and some of this is reflected—the danger was that we were defaulting to simply just the performance issues on their own. I think what we've tried to do, as we mature as a central team as well, and certainly giving advice to Ministers, is that the more we're able to discharge the performance on the one hand, but then ensure that there is proper time for strategic reflection, I think that influences the way the system behaves as well. So, our end-of-year reviews over the course of this last three years—and I've been the chief executive in this period of time—have changed from very performance dominated, I think, to more of a balance now—part A, part B—which allows us time for the strategic reflections. It's easier to do that with some of the organisations that have got approved plans in place, because, almost, they're delivering the performance, so it's a bit more of a given.

[168] For particular organisations recently, though, we've introduced a more

strategic end-of-year review. So, performance, inevitably, will dominate, but we've allowed Cardiff, ABMU and Hywel Dda, some time for my central team to just meet with them, just on their strategic intentions on the plans. And I think that's also been a real benefit as well. So, I do think the system has moved on. I think some of the reflections in the report are accurate, but I do feel that, over this last 18 months, we've been able to start demonstrating an evidence base that we're focusing on the strategic agenda too.

15:15

[169] **Neil Hamilton:** I can see that this is still work in progress and it might be fairer to ask these questions next year rather than this year, but nevertheless, if we look at a couple of the bar charts that are in the auditor general's report, namely figures 4 and 7, which are—and you don't need to look at them—in relation to the annual savings that have been achieved by the various boards on the one hand, and their capital spending programmes on the other, you can see there that there is a definite year-end effect of increased savings or increased spending, which, on the face of it, indicates that this is a last-minute response to where you've got in the course of a year. As the pattern is the same year in and year out, it doesn't look from that as though anything very much has changed from the perspective of having a longer term, more strategic vision of how to deliver both savings and capital spend.

[170] **Dr Goodall:** I think it's a more considered position than that. Again, Alan—it may be worth him just outlining the financial side. But I would agree with you that we are at the end of the first three-year cycle and there will be a whole series of subsequent three-year cycles that we can continue to learn from at this stage. So these are still early days in developing. I just wonder whether, Alan, even if it's just some of the capital reflections and maybe the way in which that might distort, a little bit, the picture that Mr Hamilton has set—.

[171] **Mr Brace:** There are a couple of things that we're more deliberately changing. One is that broader conversation around how we're using the 100 per cent of resources we've got available. We've often had perhaps too many conversations about a £20 million deficit rather than what you're getting for the £1.1 billion or a billion that you spend. So, some of the work that we're doing on that, I think, is going to be important to start to mature the system and start to perhaps raise the bar to some more strategic issues. But we have got some more and more basic practical things to resolve.

[172] So, the savings are still an issue for us. But it's curious that, if you look at the organisations we've got in intervention—we're spending a lot of time with them—because they are trying to get on top of their resources, they've implemented methodologies like 30-day improvement cycles. So, they're working on translating opportunities into delivery within a 30-day cycle, which is a good methodology. When their monitoring returns come in, they're all in twelfths. So, the actual reflection of what they're telling us—that caution, I think, and perhaps more of a traditional conservative approach, is something that we've got to work with them on, because, to some extent, we'd rather them stretch early and be a little bit more ambitious around some of their delivery and reflect that a bit more in their monitoring.

[173] I think on the capital side it's quite different. I think the report picks up the cash side of things—what was drawn down rather than what the spend was. So, if you look at it, 90 per cent of our capital programme is allocated before the start of the year for very specific schemes that have got very detailed profiles associated with them. So, I think the savings is an area for development; the capital I'm more comfortable with.

[174] **Neil Hamilton**: If you look at the savings figure—this is figure 9, I think—the non-recurrent element of the savings has been rising year in and year out. Again, that seems to indicate the lack of longer term thinking. There's still a lot more work to be done.

[175] **Mr Brace**: Again, there's probably a different—. We're looking at the aggregate data, but there's probably now a very different position on some of those boards with approved plans—they're probably much more doing things strategically and recurrently. But as I said, with ABM, you could see, almost, signs of distress that they were overly reliant on some of the non-recurrent measures, which led to the intervention. So, part of the support that we're now putting in place, when the governance reviews and other things kick in, is to make sure that the boards are getting a sensible balance from putting themselves recurrently into balance, albeit that any healthcare system will rely on a certain element of non-recurrent stuff and that's not necessarily a bad thing.

[176] **Neil Hamilton**: No, indeed. Another question arising out of that is the fact that the boards still, within the rolling three-year budgeting cycle—. That means that they have to have an annual break-even figure nonetheless, so they have to have a kind of schizophrenic approach to this: break even at

the end of every year and an overall balance within the three-year period. I was wondering to what extent these two objectives might be in conflict with one another and make it more difficult to achieve the longer term strategic thinking aims of the Act.

[177] **Dr Goodall:** We do have to focus on both of those areas, and I guess ultimately what we're trying to do is to find some way of giving some inherent headroom and flexibility in the system that allows the full financial flexibilities to be drawn down—so, a really positive direction of travel stated by an organisation that, for want of some pump-priming funding, could probably release some further savings over time. I just wonder, Alan, whether you'd want to respond.

[178] **Mr Brace:** Yes. It was one of the challenges for me coming in as a finance director into this system, because, for the first time, I had to keep an eye on how we're using all of the resources in the long term and how we're addressing inequalities. So, in Aneurin Bevan, it's making sure we had the right resource invested in Blaenau Gwent for the needs against Monmouth, and that thinking around how do we strategically manage that resource and move it around in service terms. But I also had the usual discipline of running operational services, running hospitals, and that needed a very particular beat on it around delivery. So, I almost created—. I had to create a finance function where I had certain people on the use of resources, tracking that more strategically, as well as just the daily operational delivery that tends to be more weekly, monthly, annual, and you need to do both. I think that where you get into trouble is if you get that too much out of balance and do more of the one and not enough of the other.

[179] **Neil Hamilton:** Right. And my last question is a really simple one: why has no NHS body so far made use of the financial flexibilities that are allowed? Because that was one of the benefits, supposedly, of the legislation.

[180] **Dr Goodall:** I think it goes back to the point I was making, which is that our wish is to create some flexibility, some headroom. The Cabinet Secretary has referred to the concept of a transformation fund that would allow organisations to engage in a different way. And, as we've been going through the process of trying to get all organisations on the right track, what you do need is organisations to be stepping up and over-delivering and over-committing, because we've still got a responsibility to make sure that the MEG budget balances, as well as to oversee the NHS delivery side. But, certainly, there are other organisations that tested this early. Cardiff made an

early statement of intent with a plan that was a year ahead of the plans—I think that's referred to in the report, from memory, as well. But, unfortunately, the subsequent year, they ended up with a deficit problem again and they weren't quite able to show confidence in the way they'd approached this as well. But, as a principle, I think it's absolutely there to be used and embraced, but we have to have a mechanism for creating the funds, which requires flexibility from organisations that are doing better.

[181] **Mr Brace:** Yes, and I guess, if you look at it, 90 per cent of the resources are already out there, so the flexibility exists in the boards themselves. I guess that most of those in approved status have taken advantage of that; they are actually managing now those resources over the medium-term themselves. We've only had one request, I think, initially in a draft plan that came from Cardiff, to take advantage of the flexibility, but, when tested, there wasn't the rigour in their future delivery to justify it, and I guess that moved them into not being an approved organisation. So, so far, nobody's asked for it, because I guess they probably think they've got that flexibility, I hope.

[182] **Dr Goodall:** And if you have 10 organisations all using their financial flexibilities then you end up with an overall breach of the budget, which is why we have to be realistic. But I do still think we have to be quite ambitious and challenging on this.

[183] **Neil Hamilton:** You're the conductor of the orchestra.

[184] **Dr Goodall:** Indeed, on some days. [*Laughter.*]

[185] **Nick Ramsay:** What a romantic way of putting it. We're rapidly running—well, we have run out of time, but if I can just draw this to a conclusion, we've spoken about the current in-year spend: what's your assessment of the financial position at the moment and what the end-of-the-year position is going to be? Are we likely to see other, further in-year funding necessary?

[186] **Dr Goodall:** I think where we are at this stage is seeing a position where we don't feel we've deteriorated from last year, and, in fact, probably at the outset of the year, probably feel that we are in a better position in general terms. As the Cabinet Secretary was outlining to the health committee recently, we've judged at this stage—because we are eyeballing individual organisations and reinforcing the accountability, although

allocations have gone out to organisations on the one hand, what he has done is held back about £95 million-worth of funding within the MEG budget at this stage, because we want to have confidence that organisations are going to come good on some of their plans at this stage. So, I think our expectations during this year are that we're certainly seeing a lower level of financial pressure at the start of this year. I think the NHS is always able to spend to whatever amount—you know, it's a very large budget; it represents half of the Welsh Government's budget—

[187] **Nick Ramsay**: That was very carefully answered. You should be in politics with an answer like that. You don't have to answer that. I'm still not sure whether there's going to be a need for further in-year funding, but I think somewhere within that answer you suggested what your expectations were. Finally, in terms of the review of the funding formula—I think Neil McEvoy touched on this earlier—why is it taking so long and what are the options if the review shows that some health boards are substantially overfunded or underfunded?

[188] **Dr Goodall**: We've reflected a little bit on the zero-based budget, but I can ask Alan to just give you a very simple overview of a financial allocation formula that's been in place for many years.

[189] **Mr Brace**: Yes, we've been using the Townsend formula. We've been updating that based on needs analysis, and that is the mechanism that we distribute resources, particularly the additional growth resources, within. It's a formula that is almost two decades old now, so is in need of review. We've commissioned—

[190] **Nick Ramsay**: We've been talking about the Townsend formula as long as the Barnett formula—well, as long as I've been here. Sorry.

[191] **Mr Brace**: Yes, absolutely. But it's been updated; it's the one in use. There is an opportunity now, I think, to begin some work to look at an alternative, and we'll be putting some recommendations to the Cabinet Secretary to do it. I think we've been waiting on the zero-based budget review to tell us a little bit about why the formula hasn't worked in the way we thought it would in one part of Wales—in every formula we have the debate about the impact of urban pressures against rurality and sparsity. So, that was quite an important piece of work, I think, for us to factor in before we make some recommendations.

[192] **Nick Ramsay:** Great. Okay, thank you. Can I thank our two witnesses, Alan Brace and Dr Andrew Goodall, for being with us today and answering our questions? We've run slightly over time, but thanks for your generosity with your time. It's been very helpful for us. It was something that the previous committee wanted us to revisit and I think it's been very beneficial. We'll send you a transcript of today's proceedings for you to check for accuracy.

[193] **Dr Goodall:** Okay. Thank you, Chair.

[194] **Mr Brace:** Okay, thank you.

15:26

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod ar gyfer y Busnes Canlynol
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting for the Following Business

Cynnig:	*Motion:*
bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod a'r cyfarfod ar 17 Gorffennaf 2017, yn unol â Rheol Sefydlog 17.42(vi).	*that the committee resolves to exclude the public from the remainder of the meeting and from the meeting on 17 July 2017, in accordance with Standing Order 17.42(vi).*

Cynigiwyd y cynnig.
Motion moved.

[195] **Nick Ramsay:** I propose, in accordance with Standing Order 17.42, that the committee resolves to meet in private for items 5, 6 and 7 of today's meeting, and for the meeting on 17 July. Are Members content? Good.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 15:27.
The public part of the meeting ended at 15:27.