Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 17 Gorffennaf 2012
Tuesday, 17 July 2012

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives

Mike Hedges	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Gwyn R. Price	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Lindsay Whittle	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Matthew Coe	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

Sarah Beasley	Clerc Clerk
Dan Collier	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Tom Jackson	Clerc Clerk
Sarah Sargeant	Dirprwy Glerc Deputy Clerk

Dechreuodd rhan gyhoeddus y cyfarfod am 9 a.m.
The public part of the meeting began at 9 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody, and welcome to today's meeting of the Public Accounts Committee. I have not received notification of any apologies or substitutions this morning. I remind everybody that headsets are available for use for amplification and for the translation facility. Everybody will be aware that the National Assembly for Wales is a bilingual institution. I also request that everybody turn off their mobile telephones and other electronic devices, as these can interfere with the broadcasting and other equipment. Finally, in the event of an emergency, we should not panic but relax and follow the instructions of the ushers.

Cynnig o dan Reol Sefydlog Rhif 17.42 i Benderfynu Gwahardd y Cyhoedd
Motion under Standing Order No. 17.42 to Resolve to Exclude the Public

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

the committee resolves to exclude the public from the meeting for the discussion on items 3, 4, 5 and 7 in accordance with Standing Order No. 17.42.

[3] I see that there are no objections, so we shall move into private session. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 9.01 a.m.
The public part of the meeting ended at 9.01 a.m.

Ailymgynullodd y pwyllgor yn gyhoeddus am 9.53 a.m.
The committee reconvened in public at 9.53 a.m.

Sesiwn Friffio gan Archwilydd Cyffredinol Cymru ar Adroddiad Swyddfa Archwilio Cymru 'Cyllid Iechyd'
Briefing from the Auditor General for Wales on the Wales Audit Office Report 'Health Finances'

Nid oes recordiad ar gael o'r cyfarfod rhwng 9.53 a.m. a 9.54 a.m.
No recording is available of the meeting between 9.53 a.m. and 9.54 a.m.

[4] **Mr Thomas:** Thank you, Chair. I have Gillian Body with me, together with Matthew Coe, the project manager who undertook the review of the finances. To put this in context with other reports that have been produced on the national health service, I will give some opening remarks, as you suggested, and Matthew will then take us through the report in a little more detail. Gillian can then comment on another report that came out recently, which was from the National Audit Office, but we participated in it in respect of the comparative data across the UK.

[5] You will recall that, in October, I produced the report, 'A Picture of Public Services 2011', which identified the significant financial and operational challenges facing the NHS in Wales. You took evidence on that report from the NHS Confederation and the chief executive of the Aneurin Bevan Local Health Board in February. Since then, the end of the financial year has come for the NHS, and I placed narrative reports on the financial statements of four local health boards on the achievement of their financial targets in a document on which I issued a press release of which I think you have copies.

[6] The National Audit Office, as I said earlier, has published two recent reports in this area. One, which has been copied to you, is 'Healthcare across the UK', which is a comparison of the NHS in England, Scotland, Wales and Northern Ireland. The National Audit Office, like us and the other two national audit offices, has also produced reports on NHS finances.

[7] So, this report sits among a number of reviews on the general subject of NHS and health finances. It provides a more detailed assessment of the financial provision across the NHS bodies in Wales, drawing on financial data from the budgets of the Welsh Government and NHS bodies over a six-year period to 2011-12. Basically, the aim of that is to see how the financial pressures were managed in the past. It also takes the future financial forecasts to

look ahead at the short and long-term challenges in light of the progress that the NHS has made thus far.

[8] My overall conclusion is that with the NHS and other public services facing unprecedented financial challenges in terms of the budgets and finances that are available to them over the next five to six years, the historical patterns of funding NHS bodies in Wales are not sustainable. There have been improvements in cost control and monitoring information in recent years, and the savings that the NHS bodies have reported over the last two years have been significant. However, more radical changes are needed to provide a modern health service in Wales, while, at the same time, staying within tight financial constraints.

[9] Health budgets have increased each year between 2006-07 and 2011-12, and in each of these years NHS bodies have received additional funding from the Welsh Government. Going forward, we estimate that the NHS faces real terms cuts in budgets, with a significant and growing gap in the order of £873 million by 2014-15. Capital budgets fall by 36% in the same period. This is a tougher financial settlement than for the other three countries in the UK. We considered those figures in terms of 'A Picture of Public Services'.

[10] There is a growing recognition, as you heard in the evidence from the Welsh NHS Confederation in February, that the status quo is simply not affordable. In 2011-12, there have already been moves to address this. Again, NHS bodies reported quite significant savings. They provided more detailed financial information for the Welsh Government. They have enabled earlier decisions to provide additional funding on a recurring rather than on a one-off basis.

[11] The use of an advance of funding to four health bodies has also sent a tougher message on financial accountability. As you know, four health boards were able to balance their budgets this year by anticipating expenditure. That makes the situation more difficult for them in the forthcoming year.

[12] Looking to the future, in the short term, NHS bodies again face a major challenge to manage their budgets, and to make more savings on top of those already secured. A review of the financial regime to move the focus away from annual financial targets is something that deserves to be supported. Greater clinical engagement in budget setting should also encourage greater financial ownership and a move towards sustainable reform.

[13] In the long term, there are some positive signs that the NHS will be prepared to take the tough choices. Making the necessary system-wide changes will, however, need strong leadership and widespread support and engagement from all stakeholders, patients and the public. There is a cost associated with these changes that needs to be identified quickly and managed. That was the reference to the catch-22 situation. There is a cost in moving from the current to a future stage that has to be absorbed.

[14] However, the financial constraints—I would stress that this is a report on health finances—are one of only several arguments that have to be taken into consideration in moving to a modern, sustainable health service in Wales. On that note, I will allow Matthew to draw out a few more details from the report.

[15] **Mr Coe:** Turning to the findings of the report in a little more detail, you can see that the report is structured on a chronological basis. It considers the historical funding patterns between 2006-07 and 2010-11, the latest financial year, namely 2011-12, and then looks forward to 2012-13, and beyond.

10.00 p.m.

[16] The report is a high-level analysis of financial information, of the Welsh Government budgets and the monitoring and return information that is provided by individual local health boards. We have not gone down and looked at the financial management arrangements within individual health boards for the purposes of this report.

[17] Some key themes come out of the report that span all three of its sections. I will take you through a few of those now. The nature and type of additional funding that has been provided to the NHS bodies has changed significantly over the last six years. First, the additional funding, and the reasons for why it is needed, has changed. Before 2009-10, as figure 7 on page 17 shows, the funds were largely there to support specific schemes, initiatives and cost pressures, such as improved waiting times and swine flu initiatives. After 2009-10, a greater proportion of that additional funding has been there to enable NHS bodies to break even, and to balance the books.

[18] Secondly, additional funding was provided before 2010-11 on a non-recurrent basis. It means that the cost pressures are, effectively, rolled over into the coming year as an underlying deficit. That has been done through a combination of several methods, including end-of-year flexibility on budgets with the UK Government, as well as by using something in the region of 42% of Welsh Government central reserves. That is not a sustainable position. In 2011-12, there was a step change in the way that that was approached, in that the Welsh Government provided a large proportion of this additional funding on a recurrent basis. Therefore, it will form part of the funding allocations going forward for the NHS bodies. That goes some way then to addressing that underlying deficit.

[19] Finally, the Welsh Government took that decision to provide the additional funding earlier in the year. Figure 16, on page 31, indicates that the additional funds were provided in month six, as opposed to months 10 and 11, as they had been in previous years. The greater detail that has been provided by the local health boards in their monthly monitoring returns to the Welsh Government helped that faster decision-making process.

[20] There are a few issues that the committee may wish to explore with the Welsh Government, particularly around how it will manage the financial position on NHS bodies without resorting to funds outside the health revenue budget. You might also want to ask what response it has made to our recommendations around the consistency of some of the financial data that have been provided that inform those decisions, and the consistency perhaps between what the bodies tell the Welsh Government and what they tell themselves.

[21] The second theme is the fact that the NHS bodies have made significant efforts to make savings. They have reported significant savings over the last two years: £314 million in 2010-11 and £285 million in 2011-12. The vast majority of these savings—some 87%—are recurrent, and so they are a permanent cost reduction. However, what we have seen is that there is a greater proportion in 2011-12—that is, £38 million—that are non-recurrent or one-off savings. So, again, there is more picking of low-hanging fruit for the one-off savings that can be made. There is a question as to whether those sorts of levels of savings can continue to be made in those particular areas.

[22] Figures 11, 12 and 13, on pages 25 and 26, provide additional detail around what those savings are, the levels of recurrent savings, and which bodies made those savings. There is a theme that those bodies that made those savings evenly throughout the year achieved the higher level of recurrent savings; those that did not, but end-loaded their savings towards the end of the year, had a higher level of non-recurrent savings. If you like, they were trying to close the gap faster, using one-off savings methods. The type of savings has also differed significantly from what was originally planned. As you can see from figure 11, I believe, some of the workforce modernisation savings were behind plan in terms of the scale. They

have been offset by higher levels of procurement savings, and where, for example, there is a higher level of non-recurrent, one-off savings.

[23] Therefore, there are two issues that you may wish to consider further. First, can the NHS bodies continue to make savings of this magnitude while maintaining and improving the quality and level of services? Secondly, in terms of the Welsh Government's workforce framework, what is being done to achieve those objectives of reducing management costs and ensuring that the workforce costs are affordable in going forward?

[24] The third theme is that there are some positive signs that the tough choices to deliver some long-term change will be taken. In the coming months, the health boards will be publishing their regional plans on the way that they will reconfigure and deliver services going forward. The Welsh Government has also told us about a number of ongoing reviews. In response to some of the committee's recommendations in the report, 'A Picture of Public Services'—recommendations 3, 4 and 5—there are a number of things that they are taking forward, which includes the wide-ranging review of the financial regime that was discussed, and also, as Huw mentioned, developing budgeting systems that involve clinicians in the day-to-day or initial decision-making process. We think that being able to involve the clinicians more is an improvement because, in a largely demand-led service, the clinical decisions and actions drive most of the costs from that perspective. Again, it may be useful for you to ask the Welsh Government for some more detail on those reviews and their desired outcomes, and perhaps consider the timetables if you were to take further evidence on this area in the light of those previous recommendations and responses.

[25] Finally, the level of service change required to deliver a modern, sustainable health service in Wales will have a cost attached to it, as Huw has already mentioned. We have highlighted in figure 21 on page 35 of the report that the estimated funding gap over the next three years will be somewhere in the region of £870 million to £1 billion. Closing that gap, while maintaining the quality of services and safeguarding patient safety, will require some changes to the way that services are delivered. The current configurations are simply not financially sustainable in the long term. It is very likely that a cost will be associated with that: for example, if a future service is to be provided in a primary care setting rather than in an acute care hospital, there may need to be some investment in buildings and equipment to be able to facilitate that. Similarly, it may simply not be possible to introduce a parallel service and have a changeover period; you may have to simply stop one service and start the new one.

[26] The level of capital funding, I think, is one thing that we pick out in this report. It reduces significantly by one third—36%—over those three years. Unlike local government, the Welsh Government and NHS bodies are unable to borrow funds to be able to help fund that. So, there is a requirement, or a need, for the Welsh Government and NHS bodies to consider every possible funding option available to them to help manage these costs in the next three years. However, as Huw has already mentioned, until the regional plans are released and considered, the associated costs of those are simply not known. Therefore, the committee could ask the Welsh Government what the estimated costs of those changes might be.

[27] **Jenny Rathbone:** I think that we already have that on the list.

[28] **Mr Coe:** Yes, I think that you might. Similarly, you could ask what it is already doing to try to identify some of those new funding sources or to enhance existing funding sources that would help to smooth that process. Perhaps I could now hand over to Gillian.

[29] **Darren Millar:** I would appreciate it if you could be brief, Gillian. We have around 20 minutes left.

[30] **Ms Body:** I will be very brief. I just want to draw your attention to the National Audit Office's report, which was published at the end of last month, called 'Healthcare across the UK'. It compares four nations within the UK. We participated in that NAO report, as did the Northern Ireland Audit Office and Audit Scotland. It provides some useful data, comparing the four parts of the UK in terms of health outcomes, spending, delivery and performance in the health services. The report points to the limited availability and consistency of data across the four parts of the UK, which makes benchmarking difficult. The NAO had to use a number of proxies for indicators that it wanted to use to compare. As a consequence, it did not conclude whether any health service was achieving better value for money than those in other parts of the UK. It said that where comparative data are available, no one nation has been consistently more economic, efficient or objective than the other. I draw it to your attention because if you decide to undertake an inquiry on health finance, you may find that that report contains some useful context in terms of how Wales compares with other parts of the UK.

[31] **Darren Millar:** I will ask one question to get the ball rolling and to help inform the committee on whether it should undertake an inquiry: what evidence did you take on how the NHS managed its finances? Does it manage the money that it gets well? Were you able to determine that as part of this review?

[32] **Mr Thomas:** As Matthew said, this is not a review of how each individual NHS board has managed its finances. We have looked at the global amount that it has received, how it has managed its targets in terms of reductions that it has achieved and the extent to which they are recurrent or not. There are issues, as you know, that we intend to look at, such as specific cuts related to medicine management; that is one area on which we will produce a report for you. We take specific cuts and look at how boards have managed those aspects of their budgets. However, this is about stepping back and looking at the global scene.

[33] **Darren Millar:** It is a very bleak picture.

[34] **Jenny Rathbone:** The auditor general said that the settlement in Wales is more disadvantageous than in the other UK countries. Why are you saying that, because when you look at the comparative document, spending per person on health services in Wales is £2,017 whereas, in England, it is only £1,900? So, I do not understand why you assert that the settlement is worse in Wales. It is on page 177 in my hymn book; I appreciate that in the National Audit Office report, it will be under 'Key facts' on page 4.

[35] **Mr Coe:** The English average is an average across nine regions within England. There are some specific regions within that that dramatically reduce the average. The south-east is one such example. Certainly, when we have been in discussion with Welsh Government on the demographics that Wales has, there are certain key areas of England such as the north-east and the north-west that are more comparable than looking purely at the English average. When you consider those, the figure is around the same ballpark.

[36] **Jenny Rathbone:** So, do you have figures for the different funding per person in those nine different English regions?

[37] **Mr Coe:** Yes, they are shown in figure 5 on page 16 of the NAO report.

[38] **Mr Thomas:** Figure 4 of that report gives you the forecast, which shows that the planned expenditure in Wales on health services per person drops over the next four years.

[39] **Darren Millar:** It looks as though it will be lower than that of all of the other nations in the UK.

[40] **Mr Thomas:** The figures, as you can see, have been snaking, particularly in terms of expenditure in 2013-14, and in 2014-15, when we drop below the English average.

[41] **Julie Morgan:** I was interested in what Huw said about the fact that there should be greater clinical engagement in budget setting. Could you tell us how much clinical engagement there is generally at the moment, because it seems to me that one of the big issues is not the amount of money, but how it is used? In these comparative figures, you could see that the other countries had fewer acute admissions and with greater clinical involvement in budget setting. Could those issues be tackled at the same time as looking at the financial management? However, when you look at the life expectancy figures, which I suppose is the ultimate aim of the health service—to enable one to live as long and as healthily as possible—Wales does not come out of it too badly. Could you comment on that?

10.15 a.m.

[42] **Mr Thomas:** I endorse your comments. However, we have a mixed picture, particularly when you look at the NAO report—we score well in some areas and lower in others, if we are trying to find a perfect system. In terms of good practice, the need to get clinician involvement is essential. It means that there must be greater involvement by the health boards, because one clinician's cost savings may be another patient's safety risk, but the totality must be considered.

[43] Do you wish to come in on this point, Matthew?

[44] **Mr Coe:** Yes. We have not looked specifically at the levels of current clinical engagement decision making. Anecdotally, there is some good engagement, but I would not wish to comment across the piece on the scale of it. It is an area for improvement going forward.

[45] **Ms Body:** Regarding the comparison in the NAO report, the figures are about life expectancy—it does not tell you how healthy those lives were. That was one of the indicators that the NAO would have liked to have pulled out, but it faced a lack of availability of data to be able to demonstrate that.

[46] **Julie Morgan:** There will be huge variations in Wales up the line.

[47] **Ms Body:** Absolutely. People may be living longer, but they are not necessarily having a well life.

[48] **Darren Millar:** Thank you. Aled has the next questions.

[49] **Aled Roberts:** I wish to develop Julie's theme. I got two messages from the NAO report. I do not know whether any analysis has been done of this, but Wales appears not to perform as well in the NHS on the level of emergency admissions. There was some explanation that that might be down to demographics, and that, where there is a more elderly population, the number of emergency admissions may be greater. However, it is also about the length of stay, and the impact of that on acute services' budgets in particular. Has any work been done—either in the NHS, or by you—to try to burrow down into that? Some of the figures are quite stark regarding the differences and whether it is because there is a more traditional approach in Wales.

[50] **Ms Body:** The NAO report pulls out the variations, but what it states is that that points to the need for further examination to understand those differences. That is a good question to put to the NHS in terms of what it is doing with this, to see whether it could improve its services and deliver better value for money.

[51] **Darren Millar:** Oscar has the next questions.

[52] **Mohammad Asghar:** I am looking at page 214 of the report. It is a wonderful report. However, there is a graph on page 214 of the time waited for selected hospital procedures in the NHS in 2009-10. I have had many complaints that the NHS is going from bad to worse. That is true for so many patients. I will give you an example. In 2009-10, it took fewer than 40 days for a patient to be treated for an angiography. Now, if someone goes for heart treatment, or for a test to the doctor, it takes eight weeks to get an ECG report from the hospital; one of my constituents complained to me after waiting for 12 weeks. I arranged for the doctor in that case to get the report, which came after 12 weeks, and that was just an ECG report. The doctor's statement notes that it will take another 12 weeks before an angiography will be done. Can you imagine that? Two years ago, it took less than 40 days to be cured; now, people are suffering. Is that what you are saying—that this cost has dropped? It has not dropped; it is lingering on and patients are suffering. That is what is happening in the NHS. This is only the most recent case that has happened, and I believe that Lesley Griffiths knows about it—I have spoken to her.

[53] **Darren Millar:** Is there any evidence that services are deteriorating as a result of financial pressures?

[54] **Ms Body:** There are concerns in Wales about access. Some of that comes out in the information in the NAO report, comparing access in Wales with that in other parts of the UK. That is an area where they are slightly deteriorating from where they want to be.

[55] **Mr Thomas:** I think that there are two issues here. One relates to access, and the other goes back to the issue of the configuration of services in Wales. As the report shows, we are clearly facing financial pressures. We need to be asking the NHS what it is doing in order to take account of the fact that these are the budgets and that, as our report indicates, the cost of some of the treatments needed is rising. How are we going to organise things in order to avoid the sort of delay that Oscar has just referred to? It is unacceptable to have that sort of delay in treatment.

[56] **Mike Hedges:** I want to talk about capital. You refer to the fact that local authorities can borrow. However, more importantly, local authorities can get capital receipts. I would say that that is the biggest problem with health. You have lots of hospitals and lots of land, but it is not in their financial interest to release that land. The land will either be taken over by other parts of the Welsh Government or the money from the sale will go into a central pot. It is almost like going back 20 years to the situation in local government. You have made no suggestions about health being able to keep some of the receipts from the sale of land or buildings in order to allow the improvement of the estate, which is what local authorities have done over a long period of time. Would you consider making a recommendation along those lines? Otherwise, we will just be stuck as we are. Why should they sell the land around the hospital that is unused? They might as well keep it because selling it does not do them any good.

[57] **Mr Thomas:** I would just make one comment, which is that local government bodies are separate bodies. NHS Wales is integrally part of the Welsh Government. Yes, it operates on the basis of its own finances, and there is a certain degree of delegation to the boards and so on. However, with regard to finance, we are looking at one block—the Welsh Government block. In a sense, the issue is how the Welsh Government intends to utilise the totality of its estate, including the NHS, in the best way possible. That includes sale and purchase. In relation to the River Lodge in Llangollen, you heard last week about the procedure that the Welsh Government goes through with regard to a particular block of land and how it will be deployed. The first bit is within the governmental estate. However, it is certainly true that you

are sitting on a considerable estate, and there is a question about whether you can make it work more effectively. It is unfortunate that we have to face a range of decisions now at a time when finances are tight. We are in a recession, and land values may have slipped.

[58] **Lindsay Whittle:** That is a good point about selling land. Leasing land might be an idea. However, I would not favour selling the land around hospitals at the moment because you are not going to get the price for it.

[59] **Darren Millar:** It would certainly be interesting to get the views of the NHS on that. You referred in the report to the difference in the financial regimes for trusts and health boards. Is the land issue treated in the same way by trusts and health boards? Is there no distinction in the way they can deal with surplus land stocks that they might be able to sell off?

[60] **Mr Coe:** It goes through Welsh Health Estates, which is the very particular facility used by health boards and trusts to buy and sell land.

[61] **Darren Millar:** So the treatment is identical. Okay, thanks.

[62] **Jenny Rathbone:** I am afraid that I am still fussing about whether Wales is less well funded than England, because this is one of the urban myths constantly referred to. I have found figure 5 on page 16 of the second report. The north-east of England is normally considered to be the region most similar to Wales, and we are compared in terms of our economic performance and so on. The funding for the north-east is comparable to that for Wales, but it is slightly better per person in Wales. I am not denying that we have a huge problem; I am just saying that the issue is not the absolute level of funding but what we are spending it on.

[63] **Mr Thomas:** First, the figures that we use in the report were signed off by the Welsh Government, so it is not an issue of me reading a different set of figures to the Welsh Government. What I do in my report is set out the current figures going forward; they are producing a squeeze. I clearly do not have the degree of detail in relation to NHS comparisons in Scotland and so on, which the National Audit Office has, but you will see that, in figure 4 on page 15, the Welsh expenditure is dropping. Currently, I would agree with you: if you look at 2010-11 and 2011-12, you will see that the average expenditure in Wales is above the English average.

[64] **Jenny Rathbone:** So, you are referring us to the proposed drop, because of the cuts.

[65] **Darren Millar:** Spending per capita is just one of many indicators.

[66] **Jenny Rathbone:** I agree.

[67] **Darren Millar:** We do not have much time left, but I am conscious that there are some issues that we want to try to cover before the committee decides how it wants to move forward on this. Auditor general, you refer in the report to the brokerage situation, which is a recent tool used by the Welsh Government to support local health boards to meet their obligations to break even at the end of the year, which can put pressure on local health boards in the future, given that they have that extra bit of space to make up. Has the fact that local health boards have historically received bailouts—the term has already been used, so I will use it again—towards the end of the financial year hindered or caused a sense of complacency within some health boards? Does knowing that someone will come along with a bag of gold at the end of the financial year make them less resolute to address their financial challenges or deliver their promised efficiency savings?

[68] **Mr Thomas:** I would hesitate from using the word 'complacency', but it is the case that the historical pattern of providing funding at the end of the year, after delivering tough 'there will be no extra money' messages, makes it extremely difficult for the NHS finance managers. If they are trying to drive down costs and achieve savings and then, suddenly, an extra amount of money comes in, it is extremely difficult for them to emphasise to the clinicians and other operational staff that savings must be made. So, while I accept that, overall in NHS Wales, it makes absolute sense to maintain and deploy a contingency fund, you need to be careful about how those messages are communicated. The message this year in relation to brokerage is clear by the Welsh Government, which is this: 'There is a limit in this; if you need extra funds this year, they must be carried by you next year as an additional saving.' It is admittedly small in terms of percentage, but it is a powerful message, which underlines the fact that the funds are running out.

[69] **Gwyn R. Price:** Moving on from the brokerage funding for 2012-13, LHBs must be aware that they must find these savings, and that it is not just a gift that can be handed to them year after year as it has been in the past. They must therefore adjust their budgets and come in line. Do you agree with that?

[70] **Mr Thomas:** Yes. The message to them is clear. When you take evidence, I hope that you will be able to ask the LHBs how they intend to respond to that challenge.

[71] **Ms Body:** The question that we raise in our report is how challenging or realistic it will be for health boards, after securing this low-hanging fruit, as it were, to deliver the scale of savings that are needed.

[72] **Darren Millar:** Do they have to show a plan of how they intend to repay the brokerage in order to access it?

[73] **Mr Thomas:** What happened was that, if an LHB wanted to take advantage of brokerage, it was voluntarily submitted to an external review that the Welsh Government has undertaken in terms of their plans for the future and so on. So, it is a question that you can ask specifically of the Welsh Government.

10.30 a.m.

[74] **Darren Millar:** When did LHBs receive information that there was the potential to access brokerage? Were they notified in a circular of some sort?

[75] **Mr Coe:** I believe that the Minister wrote to all NHS bodies highlighting this as an option, if they needed to partake of it. In terms of timing, I think that it was in January or February.

[76] **Mr Thomas:** I think that it was in January.

[77] **Darren Millar:** Do you think that it was in January? The Minister offered brokerage last November, I think, to Cardiff and Vale University Local Health Board.

[78] **Mr Thomas:** I think that I will need to come back to you, because a letter was sent out to all LHBs and it is that one that we have in mind.

[79] **Jenny Rathbone:** Can you enlighten us on how it was that Betsi Cadwaladr University Local Health Board and Cwm Taf Local Health Board both predicted that they would break even in month 11? That is, right up to the very end of the financial year, they were saying that everything was all right, but then they had to rush to get this additional money. That is of concern, because it is one thing for organisations to say, 'It is all very

tough, because of x, y or z reasons', but when they are telling you that everything is all right and that things are under control and then the next minute they are saying that they need to go for the brokerage, is it the case that they really do not know what they are doing?

[80] **Mr Thomas:** As you see from the diagram on page 31, there appears to have been virtually no variation by Betsi Cadwaladr in terms of its forecast outturn. I find that surprising, given that other boards, as you can see from the picture, were changing and were reflecting over the course of the year on what was happening.

[81] **Ms Body:** I think that the point that the report makes is that, while there have been improvements over the financial year in terms of cost control, there is still scope to improve further, and accurate forecasting of the outturns is an area where there is scope for improvement.

[82] **Darren Millar:** It calls into question the authenticity of the reports that they are producing, does it not? Perhaps the local health boards should be raising questions as far as the governance aspects are concerned. A few people want to come in on this point. I will come to you in a second, Lindsay, but Mike first.

[83] **Mike Hedges:** I was just thinking that this takes me back to the days when I served on the Swansea NHS trust. One of the things that happened—and you can tell me whether this is still happening—was that there was a huge cost pressure at the end of the year to keep expenditure down, but come the beginning of the next financial year, all of a sudden, things exploded again and the problem started in the new year. Is that still happening?

[84] **Mr Thomas:** Let me put it this way: if you are in a climate in which you are expecting some extra funds the next year and you are in a growth situation, that burst at the beginning of a new financial year is possible. I think that, this time, the fact that we have four boards carrying forward debts that they have to repay should act as a very powerful message that you cannot simply transfer expenditure from one year to the next.

[85] **Lindsay Whittle:** It is quite clear that some boards have strict control and monitoring of not only their budgets, but their forecasts, and it is quite clear that others do not. I wonder how we share best practice and what this committee can do to urge the Welsh Government to ensure that there is this stricter control. That is essential. With regard to invest-to-save, has any thought been given to any programmes?

[86] **Darren Millar:** On the best practice front, you make some recommendations about that in your report, do you not, auditor general? Would you like to touch on that a little bit—about how you anticipate they should be sharing this best practice?

[87] **Mr Coe:** In any way they can, I think, is the short answer to that question, Chair. There are a number of small projects that are happening in every health board. There are ways in which they have approached the reconfiguration of services, the inclusion of patients in whole care pathways, and so on, that are transferable between health boards. How the Welsh Government promotes and facilitates that is probably a good question to ask.

[88] **Darren Millar:** You just touched on an important issue. We have reorganisation plans in train in different local health boards—they are all at different stages, but, by the autumn, they will be produced. You mentioned patient involvement in the planning and delivery of those services. To what extent have you been able to accumulate a body of evidence on best practice about patient involvement and how to carry the public with you when some significant challenging reforms might be necessary?

[89] **Mr Thomas:** I produced a report on public engagement in the context of local

government, and we have been carrying out some good practice seminars since then in which NHS bodies have been involved. We are trying to do that in terms of good practice within the NHS and more generally. Particularly in terms of the scale of the reorganisation and reconfigurations that the NHS needs to go through, there is a need to sell this and to build it around what the public wants. There is a need to explain it and to engage the public in that process.

[90] **Darren Millar:** On the other point that Lindsay made, on invest to save, how do you think that we can open up these savings if there is not a lot of cash in the box?

[91] **Mr Coe:** There is a pot of interest-to-save moneys to which NHS bodies currently have access. We refer to it in the report. It is around the £5 million to £6 million mark. I think that the Minister has recently approved a further tranche from that perspective, but I am sure that there are views in terms of the funding, the scale of the reconfiguration and particular things.

[92] **Darren Millar:** There are financial challenges in other parts of the United Kingdom. How are they addressing this issue of making more cash available upfront in order to deliver savings further down the line?

[93] **Mr Thomas:** Different regimes apply in other parts of the UK, but, that said, some trusts in England have had to go into receivership and others need to look at severe reductions in terms of payments to staff. So, in each part of the UK, different regimes are having to struggle, but underlying that are the same issues, namely the cost of the current provision and of the change to a new set of arrangements.

[94] **Aled Roberts:** On staffing costs—the point that you just made—do you have any sense of why some of these NHS bodies have not been able to meet the 0.8% target? There seems to be a huge discrepancy between health boards in the amount that they are spending on agency and locum staff. Is that due to shortcomings in their workforce planning arrangements?

[95] **Mr Thomas:** I hesitate to generalise, but according to the discussions that I have had with the chief executives of LHBs, most of the agency arrangements have had to reflect the need to meet the shortfall of recruitment targets. That is despite their having worked extremely hard to advertise; they are unable to attract the necessary people. In those circumstances, they fall back on the use of agency staff.

[96] **Aled Roberts:** Is there no evidence that, in some health boards a block was put on recruitment where, as I understand it, the finance director had to sign off any job vacancy for which someone was being recruited on a permanent basis?

[97] **Mr Thomas:** I think that that would be true not just in the NHS, but in other organisations. In a period when you have to reduce expenditure, you will make sure that the filling of posts is tightly controlled. By itself, I would not find that unusual, but you need to look at the general pattern of how that has been applied in a particular board, how that compares with another one and whether it is justified.

[98] **Darren Millar:** Does the potential for service reorganisation have an impact upon recruitment? For example, if a hospital moots closing a particular service down, it could be difficult to recruit to that service, could it not?

[99] **Mr Thomas:** That is true of any organisation that is rumoured to be subject to change—perhaps moving location, or whatever. Those are all factors that affect recruitment.

[100] **Darren Millar:** It is interesting that the biggest areas in terms of the use of agency staff are north Wales, where there is obviously significant concern about reorganisation, and west Wales, as far as the report is concerned.

[101] **Jenny Rathbone:** The key question is how well health boards are able to push the money back down the pipe into primary care to reduce the number of hospital admissions and so on. Now that health boards have fully integrated responsibilities, what evidence is there that they have coherent plans for beefing up primary and community care in order to keep people out of hospital? I have certainly heard some leaders—the ones in my area—say that that is the key issue: we have to keep people out of hospital, and they are going into hospital just because nobody can think outside the box about what to do with them.

[102] **Mr Thomas:** Indeed, and often the focus of discussion in reconfiguration is that secondary element of the traditional hospital. For reconfiguration to work you have to address the issues of primary and tertiary care, but also think in terms of improving the health and wellbeing of the whole population more generally. In other words, we are looking at one particular segment of changing the health of a nation. In terms of the primary element, that would be something that I would expect to see when the plans are put forward.

[103] **Mohammad Asghar:** I have a very important question. Did your investigation find any suggestion that the quality of services that are sometimes socially stigmatised—for example, mental health services—may be unduly affected by the need to make efficiency savings?

[104] **Ms Body:** In the report we have very much worked on analysing the financial information. We have not gone behind it in terms of the implications for services to patients. I suppose that is where the NAO's comparative report provides some key indicators, but I do not think that the one that you referred to is in that.

[105] **Darren Millar:** Mental health spending is ring-fenced at the moment, is it not, by the Government? It is hypothecated within local health board pots.

[106] **Mr Coe:** Yes.

[107] **Darren Millar:** So there cannot be a reduction in the volume that is spent on mental health services. I have a question on medicines management. You have a very useful table, figure 11, on the anticipated savings at the start of the year compared to the actual delivery in terms of outturn. While there were some really positive messages about targets being exceeded on procurement, for example, medicines management seems to have lagged behind. Is there any particular reason for that that you are able to determine?

[108] **Mr Thomas:** As I said, we are going to be looking at medicines management work as a separate item, but really there are two elements in terms of medicines management. One is the volume of prescription. We would want to know what that is like. The other is the individual cost of new medicines, particularly when they are in patent—new medicine is much more expensive than when it emerges out of patent—and also whether generics are used. There is a lot around that medicines management work, which is why it needs to be looked at.

[109] **Darren Millar:** Your work will look at the role of community pharmacies in that regard, will it not?

[110] **Mr Thomas:** It is looking widely, yes.

[111] **Darren Millar:** The Health and Social Services Committee has just completed some

work on community pharmacies and it was interesting to see the resistance sometimes in some parts of the NHS to working with others in order to deliver an improved service. Are there any further questions for the auditor general and his team?

[112] **Jenny Rathbone:** On that medicines management issue, I cannot find the reference now, but I thought that you were saying that it was primary prescribing that was going up. By that I understood what GPs and primary healthcare nurses get up to.

[113] **Mr Thomas:** Medicines management is primary and secondary care.

10.45 a.m.

[114] **Jenny Rathbone:** Yes. I thought that the way that you phrased it meant that where the bill has not been contained is in primary prescribing. Am I misinterpreting what you mean by primary prescribing?

[115] **Mr Thomas:** If by primary prescribing you mean—

[116] **Jenny Rathbone:** Primary healthcare.

[117] **Mr Thomas:** In terms of prescriptions, we also need to look at continuation. People will leave hospital with a prescription from their consultant, say, which the GP then carries on prescribing. So, it is fairly sensible to say that it is referenced back. Therefore, in a sense, you have to look at both together.

[118] **Jenny Rathbone:** Fair enough.

[119] **Darren Millar:** If there are no further questions, we will move back into private session to discuss how to handle this issue.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.45 a.m.
The public part of the meeting ended at 10.45 a.m.