Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Cyllid

The Finance Committee

11/11/2015

Trawsgrifiadau'r Pwyllgor
Committee Transcripts

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cynnwys
Contents

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

The proceedings are reported 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

Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Christine Chapman	Llafur Labour
Jocelyn Davies	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Mike Hedges	Llafur Labour
Alun Ffred Jones	Plaid Cymru The Party of Wales
Julie Morgan	Llafur Labour
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives
Jenny Rathbone	Llafur (yn dirprwyo ar ran Ann Jones) Labour (substitute for Ann Jones)

Eraill yn bresennol
Others in attendance

Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Minister for Health and Social Services)
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol Iechyd / Prif Weithredwr y GIG, Llywodraeth Cymru Director General, Health / Chief Executive of the NHS, Welsh Government
Leighton Phillips	Dirprwy Gyfarwyddwr Strategaeth a Chynllunio, Llywodraeth Cymru Deputy Director of Strategy and Planning, Welsh Government
Martin Sollis	Cyfarwyddwr Cyllid, Llywodraeth Cymru Director of Finance, Welsh Government

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

Leanne Hatcher	Ail Glerc Second Clerk
Martin Jennings	Y Gwasanaeth Ymchwil Research Service
Tanwen Summers	Dirprwy Glerc Deputy Clerk
Joanest Varney-Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 09:02.
The meeting began at 09:02.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Jocelyn Davies:** Good morning, everybody. Welcome to a meeting of the Assemby's Finance Committee. Before we start, if you've got a mobile device with you, could you check that it's on silent? We've had one apology from Ann Jones, and Jenny Rathbone is substituting again for her. You're very welcome here, Jenny.

09:03

Papurau i'w Nodi
Papers to Note

[2] **Jocelyn Davies:** Right, we've got one paper to note, which is the letter from the Public Services Ombudsman for Wales. Are Members happy to note that? Okay then.

Ymchwiliad Etifeddiaeth: Sesiwn Dystiolaeth 1
Legacy Inquiry: Evidence Session 1

[3] **Jocelyn Davies:** We'll move on to our first substantive item this morning, which is our legacy inquiry into the National Health Service Finance (Wales) Act 2014. We've got the Minister with us this morning. Minister, would you like to introduce yourself for the record, and your officials, and

then we'll go straight to questions, if it's okay?

[4] **The Minister for Health and Social Services (Mark Drakeford):** Thank you very much, Chair. I'm Mark Drakeford, the Minister for Health and Social Services in the Welsh Government. With me this morning I've got Dr Andrew Goodall, who is the director general of the health service; Martin Sollis, who is the head of our finance division; and Leighton Phillips, who has been the policy official leading on the implementation of the Act.

[5] **Jocelyn Davies:** Lovely, thank you. If I could start then—well, obviously, this is a legacy inquiry, so we've wondered how things have gone since the Act has been passed. Perhaps I'll start with you first, Minister, if you just want to give us your general view on that, and then I'll come to Dr Goodall, who we remember, when he was wearing a different hat, came here to advocate strongly that we should pass this legislation.

[6] **Mark Drakeford:** Chair, thank you very much. Members will remember that this was a piece of legislation that went through the accelerated procedure in the Assembly. It didn't have a Stage 1, and it didn't have a Stage 1 because the case for the change, which was to move the NHS from a one-year to a three-year planning cycle, had been strongly advocated by a series of Assembly committees, including the Finance Committee, in previous reports. During the passage of the Bill, at Stage 2 and at Stage 3—Stage 2 in front of this committee two years ago now—there were three key issues that were played out during the whole of that period. There was the issue of tolerances around the year-end. There was the issue of borrowing powers for local health boards. And there was the issue of checks and balances in the system—given that these were to be three-year plans that health boards were asked to prepare, what level of oversight would members of the public and Members of the Assembly have of that process?

[7] I think that, since the Act came into force, we've tried to take all those three things forward. The middle one—the borrowing powers—we are taking forward in the Green Paper that you will have seen, and it will fall to the next Assembly and to whoever is in the Government as to what they want to do with the result of that. But that idea has been developed and is there for people to comment on. In relation to the third, which I think was the major aspect, I think we would argue that we have put in place some strong mechanisms for the planning of three-year plans, for the oversight of three-year plans and for the approval of three-year plans. So, we're only halfway through the second year of the first three-year cycle, but we are embarking

on the planning for the third year, and I think the record will show that we have matured the process rapidly, that health boards are better at the job than they were two years ago, that the scrutiny of what they do is stronger than it was two years ago and that the reporting of what they do to the public and to the Assembly allows anyone who wants to take an interest in that a good level of insight to be able to ask the questions they would want to ask and to get the assurances they would be seeking.

[8] **Jocelyn Davies**: I can see Martin Sollis nodding while you're talking, Minister. So, he obviously agrees strongly with that. Dr Goodall, if I could come to you because, obviously, you're wearing a different hat now so you're seeing things from an entirely different perspective. How would you reflect on how it's gone?

[9] **Dr Goodall**: I have gone through a transition myself, but what I would say is that the service has really welcomed this approach, first of all to focus on their local business and their expectations for the population, but I think also accepting that this is helping to give clarity about the expectations that Welsh Government itself is setting. So, it has been a change for the service out there in terms of their experiences and, to change from an annual planning cycle into one that is more long term over that three-year period and has required a change of approach and behaviour around the individual boards. That actually has raised some issues that we need to develop ourselves. So, we've had to focus more around planning and competencies, for example, in our teams. We've needed to gather NHS Wales in a different way around the table. Even as we've been going through these first two years of implementation, we've actually kept the service very close on issues.

[10] The point that I would make perhaps just to finish this overview is that we can't set aside the planning approach from other necessary arrangements as well. So, it's very much tied into accountability and also the escalation arrangements that are in place for organisations. I think, as a package, all of those things together, including clarity about our expectations for organisations—I think they help the implementation of the plans.

[11] **Jocelyn Davies**: You mentioned culture change, which is something that you told us prior to this legislation would happen, and it was needed. Are you seeing that?

[12] **Dr Goodall**: I think we are seeing culture change. I think just looking at the organisations that have been able to pass the criteria—and we've

retained the standards around our criteria—shows that there's a maturity within the system. I think it's also required the relationships to be formed, though. So, we need to ensure that we are applying things consistently for individual organisations. Certainly, we need to make sure that, despite our good intentions, organisations do need to actually step up to the line to make sure that they are delivering both expectations and targets in that setting as well. But the key thing about the plans is they've got to get that right mix of the service expectations, the workforce and then managing with the resources as a balanced package.

[13] **Jocelyn Davies**: Yes, because, often, some organisations can say, 'If only we had this; if only we had that' and then, when they get it, there is no change and they only wish they had something else—

[14] **Mike Hedges**: Yes.

[15] **Jocelyn Davies**: Mike is agreeing with me so I probably have quite a good case. But you would say that that is definitely the case because of trying to get out of this break-even situation that—

[16] **Dr Goodall**: Yes, there is a culture change. The bit I would reinforce is that it's not only about the finance. The finance is a really important constituent of this, but we look at all of those aspects together within this. It was never to have an overnight change on issues. We need to continue to develop services. We have already learned lessons from year 1 into year 2, and even in issuing our recent guidance, which we issued to the service just a few weeks ago, there was further learning that we've actually implemented to make sure that we are responsive to some of the concerns that would continue to be expressed at times. But I think it's been a positive implementation for the service out there.

[17] **Jocelyn Davies**: Okay. Well, over what period are overspends against the plans for 2014-15 expected to be repaid?

[18] **Mark Drakeford**: Chair, I think the expectations of the Act are clear in that if there are overspends in one year of a three-year cycle, then they have to be paid back over the three-year cycle as a whole. So, in terms of 2014-15, they would have to be made good by the end of the three-year period—that's to say by the end of 2016-17.

[19] **Jocelyn Davies**: So, will there be a difference in how overspending

organisations with three-year plans and one-year plans are—no? Martin—

[20] **Mark Drakeford**: Not in law.

[21] **Jocelyn Davies**: Can I bring Martin Sollis in?

[22] **Mark Drakeford**: Of course.

[23] **Mr Sollis**: The duties are the same whether you're in a three-year plan or a one-year plan. They came into effect from 1 April 2014 and they're measured from that date on a consistent basis, whether you're in an approved-plan status or a one-year plan status.

[24] **Jocelyn Davies**: Okay. Ffred, did you want to come in on this?

[25] **Alun Ffred Jones**: Wel, a gaf i jest ofyn, felly, er enghraifft y flwyddyn ddiwethaf, 2014-15, mae Betsi Cadwaladr yn dangos gorwariant o £26 miliwn, ac fel rydym ni'n ei ddeall, mae yna orwario pellach yn mynd i ddigwydd eleni, yn ôl y darogan beth bynnag o'r—. Hynny ydy, felly, mi fyddech chi'n disgwyl y flwyddyn nesaf iddyn nhw, rywsut neu'i gilydd, dalu yn ôl yr arian yna, neu a ydw i wedi camddeall?

Alun Ffred Jones: Well, could I just ask, therefore, for example last year, 2014-15, Betsi Cadwaladr shows an overspend of £26 million, and as we understand, there is a further overspend that's going to happen this year, according to the forecast anyway from—. That is, then, you'd expect next year for them to somehow pay back that money, or have I misunderstood that?

[26] **Mark Drakeford**: No; there are two different things here. The law applies equally to organisations that have a one-year or a three-year plan. The likelihood of an organisation that was not able to provide an approvable three-year plan being able to live within its means over the three-year period is much diminished. Do I expect that Betsi Cadwaladr will be able to pay back in year 3 all of the money that it has overspent in years 1 and 2? I think that will be a remote prospect. It then will be for the auditor general to make determinations in relation to their accounts over that three-year period.

[27] But what we have to balance—what any Minister would be balancing in that third year for an organisation like that—are the financial duty to break even over the three-year period and also the obligation to go on providing a

health service to that population that is of a quality and a nature that we would want to see sustained. So, the service elements, the workforce elements, the performance elements are equally in there alongside the financial elements. The law is the same, whether you've got a one-year plan or a three-year plan; the way we will deal with the consequences will be different.

[28] **Jocelyn Davies**: Okay. Mike, shall we come to you?

[29] **Mike Hedges**: I just want to agree with what you said earlier on—I think that sometimes people use the term 'lack of cash' to hide competency issues. That's often the problem. The first question: we're talking about health boards overspending—as I'm sure you're all aware, Dr Keogh reported that in England 10 per cent of interventions, in terms of cost, either did harm or did no good. I've seen figures in Wales of 10 to 15 per cent of interventions either doing harm or no good. What can be done—? I mean, we're talking about people breaking even over three years, but if they're wasting 10 to 15 per cent of their money on things that either do harm or do no good, what can be done to actually stop them doing that?

[30] **Mark Drakeford**: Well, Chair, this is absolutely at the heart of our prudent healthcare agenda. The first principle of prudent healthcare is to do no harm. When I'm in front of clinical audiences, I'm often having to explain to them that while all doctors are taught from the very beginning that that's their primary obligation, but in practice all healthcare systems of our sort go on doing things that do create harm.

[31] We know from research at Cardiff University published recently that one in seven of all antibiotic prescriptions issued in primary care across England and Wales over a 20-year period—one in seven of them had no clinical case for being issued. In giving antibiotics to someone who doesn't need them, you end up building up that person's resistance to antibiotics when the time comes when they do need them. So, it does harm in that way. Anybody who has a healthcare-acquired infection has been harmed by their contact with the health service.

09:15

[32] So, there's no doubt that our systems do things that do harm, and we have to persuade our clinicians to eliminate those things they do that don't do any good. Being part of the Choosing Wisely movement, which is an

international movement in which authoritative clinical advice from clinicians goes on a peer-to-peer basis that says to them, 'Don't order that test because that test will tell you nothing useful in terms of—. And by ordering that test for someone who doesn't need it, you are denying the use of that resource to something more useful'. So, there is an ethical obligation on clinicians to use the resources that they have in the wisest way. It's not about saving money, but it is about using the resources we have in a way that does good by eliminating those things that we do that don't do anything clinical effectively. There is huge room in the Welsh health service, as in all health services, to move in that direction. It's why NICE has published 650 'do not do' pieces of advice to the service, but they get very little attention really, in the public domain particularly, compared to the piece of NICE advice that tells us that there is something else we should be doing. There are 650 things not to be doing.

[33] **Jocelyn Davies**: Is there any evidence that the clinicians are taking any notice? I mean, I think I've mentioned to you before that my GP says, 'If you take antibiotics, you'll have that for a week; if you don't, you'll have it for seven days.' It'll have no impact at all, but, you see, if there's over-prescribing of antibiotics, it doesn't just affect the person who has the prescription; it affects everybody else—

[34] **Mark Drakeford**: It does, yes, I know.

[35] **Jocelyn Davies**: —as well, because this could be a real problem for us later down the line. Is there any evidence that clinicians are listening to that NICE advice?

[36] **Mark Drakeford**: Well, I think we've succeeded enormously in getting our prudent healthcare agenda to be grasped by the health service here in Wales. We very seldom give ourselves credit in Wales for some things that we do internally that, outside, people are really interested in. So, our chief medical officer was in conferences in Australia over the summer, where Wales was on the front of the stage because of the way in which our clinical community is grasping this agenda. It's variable to begin with, as you would expect, but if you wanted to see where it was at its very best, I think you'd go to Aneurin Bevan and see what Paul Buss, the medical director there, and his deputy who's a GP in the area, are doing to make sure that this issue of clinical value—that what you are doing is actually the very best you can do to do good in the lives of patients—I think, is right at the heart of what that health board is now trying to achieve.

[37] **Jocelyn Davies:** So, do you think the figures that Mike Hedges quoted were based on English experience?

[38] **Mike Hedges:** Ten per cent is what Dr Keogh reported from England—

[39] **Jocelyn Davies:** So, would you say that, in Wales, it might be better than that then?

[40] **Mark Drakeford:** Do I think that we are spending less of our budget on things where better use could be made of that money? I would doubt it. But I think we are further along the journey to making sure that we will be in that position because of the way that we've developed this agenda in Wales.

[41] **Jocelyn Davies:** Back to you then, Mike.

[42] **Mike Hedges:** I was going to say that perhaps sometimes you don't give either you or your colleagues the credit that perhaps you deserve for the progress you are making in dealing with difficult problems. One question on it: you say that there are 650 that NICE have identified—why don't you refuse to fund any of those? It would actually concentrate the mind of the finance people in the boards if you said, 'Well, you can have this, but we're not going to pay a penny towards it?'

[43] **Jocelyn Davies:** I think you ought to consider very carefully before you stop funding antibiotics. [*Laughter.*]

[44] **Mark Drakeford:** Every now and then, I find myself attracted to that sort of idea. I give you a different example in variation. So, if you look at something like tonsillectomies, people in Anglesey lose their tonsils at twice the rate of people in Wrexham. Same health board. I don't think you can describe it as a difference in population. It's a difference in clinical practice. And the evidence for tonsillectomies is less compelling than it used to be. Now, I sometimes think, 'Well, why don't we use financial regimes to try and make sure that we iron out some of these sorts of variations?' The problem you run into, particularly if you try to do it on the NICE guidance, is that you run into clinical judgment. NICE is guidance and it's advice, and you have to allow clinicians to apply it in the particular circumstances of the particular individual you have in front of you. And there will be people for whom a tonsillectomy is the right answer. So, it's trying to allow for clinical judgment about the right thing for the person in front of you but to make sure that, if

someone is making that decision, they are testing that decision against the advice that they've got.

[45] **Jocelyn Davies**: I suppose we should get back to the legislation.

[46] **Mike Hedges**: Okay. I was enjoying that bit. [*Laughter.*] What lessons have been learnt from the plans' approval process in 2014-15 that can be used for the future? And are you thinking of moving to a rolling three-year system, rather than three-year blocks?

[47] **Mark Drakeford**: I believe we are in a rolling three-year programme. That's what the Act sets up. The second year of any three-year period is the first year of a new three-year period, so it is a rolling way of doing it.

[48] Maybe I'll say briefly some of the things I think we've learnt, and then Andrew will have other things to say. I think the first thing I feel we've learnt from the first year is that we have to be clearer with health boards about their responsibility in terms of the oversight of the plans. The law requires the plan to go, in the end, to an open meeting of a health board and to be signed off by the whole health board. I think we've learnt that we need to make sure that health boards are discharging their own oversight responsibilities more sharply than maybe they did in the first year, and I think they will be doing that. I think we're learning, as we move into the third year, that we want to have a more differentiated approach. So, organisations that have succeeded in having plans approved for two years already—to get a plan approved in the third year, I think we are saying to them, 'You can give us a slimmer version of your plan. You can focus on the key things that you want to achieve and you don't need to send us the 100 pages of background and things that you sent us in year 1 and year 2.' But, from an organisation that hasn't had an approved plan, we will expect the full works to be submitted, so it's a differentiation.

[49] I think we've learnt that we want to try and move the process forward in time if we can. In the first year, we issued the planning framework on 4 November in 2013. We did it on 31 October in 2014, and we moved it to 9 October in 2015. So, we've gained a month in the first three years, and I think that's deliberately done, recognising the lesson of needing to move the process earlier.

[50] **Dr Goodall**: I think we've also learned that those organisations that have been able to push forward with their plans to really make it central to

their organisations are able to show lower escalation status in general terms and that they are more broadly delivering on the range of targets and expectations that we have, and they are showing their ability to push forward with actions at this stage. Certainly, we need to make sure that we're able to be focused in our expectations as well. I think one of the concerns was that, almost every year, as we revised our planning framework guidance, we would issue another quota of expectations and targets out to the service. I think particularly what we've been able to do in the shift between the year-1 learning and into year 2—. The framework that we issued four weeks ago was really saying that all of this was already within the gift of the organisations—the guidance that they'd had last year has stayed pretty consistent. We tried to draw out some elements where we would expect organisations to step up more clearly.

[51] To give two examples on the planning guidance for this year, we will be more strongly measuring the outcome of organisations on the way in which they've developed their primary care plans—the focus on GP clusters locally, the way in which they use the resources that have been announced by the Minister and Welsh Government. We've also set out expectations in that prudent healthcare reflection earlier that we would expect the financial components of their individual plans to have a much stronger focus around the value in prudent healthcare as well. But it remains an iterative process in terms of the lessons that we do learn.

[52] The areas of shortfall, however, that we still see—. With some of the leading organisations in Wales, you can really see how they've made a very concerted effort. So, if we take Cwm Taf as an example, they've really been able to push on with their local strategic development plans. But I do think we've had a deficit in the service more generally around demand and capacity planning, which is actually the number of patients, the care that needs to be offered and the treatment and how that is to be discharged across different settings. So, part of the competency framework that we've put in across Wales to support the planning departments actually allows us to focus on those particular individual issues. Leighton, as the policy lead, may be able to add more on some of the detail on some of the planning questions—

[53] **Jocelyn Davies**: Well, I know that Nick has got a supplementary, so then perhaps, Leighton, you'd come in—. Did you have a supplementary on this point?

[54] **Nick Ramsay**: Yes, we might come to it later, but what about

prevention? Is that a factor in trying to get the—[*Inaudible*.]

[55] **Dr Goodall:** Yes, our intention is to make sure that we're not simply changing the historical set of services—[*Inaudible*.]—and doing the same level of activity. We are trying to make sure that all of the assessments within the planning process start with what the population health needs are for that local community. I think there's a view, when you look at prevention actions, that, to some extent, you're looking to influence perhaps what 10 or 20 years' time looks like. I do think that there is an aspect about our public health approaches where, actually, you can put in concerted actions that actually make a difference more speedily than that. You know, we've been able to target issues over the last decade—for example, about reductions in teenage pregnancy—and you can make a difference, actually, on a year-on-year basis around these areas. But I think that's one of the tests of maturity of plans: have they been able to move from just an assessment around how many orthopaedic operations have taken place in the community, or have they been able to stand back and actually think about whether they are targeting obesity, have they been able to develop approaches to physical activity, have they been able to deal with healthy lifestyles approaches within communities? We have good examples, particularly in a couple of health boards in Wales—the Aneurin Bevan Living Well Living Longer, for example, up in Blaenau Gwent, where we're targeting this kind—

[56] **Jocelyn Davies:** That's enough examples, but yes, I think the answer—. We've got to question 2 in half an hour and, just to remind Members, I think we've got about 14 questions. Minister, your diary is packed for later on, so maybe we'd better speed up a tiny bit. Have you finished? Shall we move on to Ffred, then?

[57] **Alun Ffred Jones:** Wel, rydych chi wedi cyffwrdd ar hwn yn barod, rwy'n meddwl, ond a fedrwch chi egluro'r broses asesu, yn fyr, ar gyfer y cynlluniau tair blynedd?

Alun Ffred Jones: Well, you've touched on this already, I believe, but can you briefly explain the assessment process for the three-year plans?

[58] **Mark Drakeford:** Thank you. I hope we have said a bit about that already. So, the assessment process begins with health boards themselves. They should be building their plans up from the bottom upwards. So, it should start with primary care and the clusters that they have there. It should move through the different divisions within the health board. It should go through their sub-committees and then finally end up in a public board with

their plan. It then comes, as the Act was amended as a result of amendments moved here, to the Minister and a formal approval system within the Welsh Government. Now, before it comes to the Minister's desk, there's an approval process within the Welsh Government too where these plans are assessed. It culminates in advice to me as to which health boards in Wales have passed the robust tests that we put in place. Those who have get three-year plans approved, and those who don't end up with a one-year plan.

[59] **Alun Ffred Jones**: Ond sut ydych chi'n asesu, wedyn, y cynlluniau wrth fynd ymlaen? A ydyw'r adroddiadau hyn yn—. A oes gennych ryw feincnodau lle'r ydych yn disgwyl iddynt basio a bod yn gyson â'r cynlluniau? Ai dyna ydy'r broses?

Alun Ffred Jones: But how do you then assess the plans in going forward? Do these reports—. Do you have some kind of benchmarks where you expect them to pass and be consistent with those plans? Is that the process?

[60] **Mark Drakeford**: Yes, thank you. I should have said, maybe, when I was asked what we had learnt from the process, that one of the things I think we've learnt is the need to make sure that you stick close to the ongoing assessment of the plan through the rest of the year. Once you've signed it off, you've then go to make sure that you remain on top of it. There are mechanisms in place, regular reviews, what are called JET meetings—joint executive team meetings—that executives have with—

[61] **Jocelyn Davies**: And that's Leighton's responsibility, is it?

[62] **Mark Drakeford**: Leighton will be running all of that.

[63] **Jocelyn Davies**: Can you briefly describe that for us?

[64] **Mr Phillips**: Yes, of course. So, we take two formal looks at the plans. We look at them at the end of January. That's intentional—it's a no surprises approach. So, we give prompt feedback to organisations within a couple of weeks of doing that assessment. We try and be concise against our set criteria. So, 'What would it take for you as an organisation to move you to an approvable position by March?'. Then, following public board approval in March, we take a second look at plans formally. Just to give you an indication of the depth of analysis that we do, each plan will typically go to 10 people—10 specialists within Government and people with a service background. They can spend anything between five and 10 hours on each plan. We then

do face-to-face contact with organisations. You can only learn so much from a written document. So, some organisations will meet six or seven times, and we use a lines-of-inquiry approach. So, the things that we've spotted through looking at the written assessment we'll test in a bit more detail. We'll then take the evidence that we've gained against other organisations' auditing and looking at the health boards and trusts.

09:30

[65] So, the WAO, on an annual basis, does a structured assessment. We want to know what's coming out of that structured assessment in terms of the governance around a plan. All of that culminates, as the Minister's mentioned, in final advice to the Minister for him to make an approval or non-approval, if he's not confident, and that's why we had a limited number of approvals in the first year. We wanted to be absolutely confident.

[66] The JET process, this doesn't all end upon approval. So, we're monitoring organisations against their plans on a monthly basis. The performance management systems are doing that. Where an organisation is varying from plan, it links to the escalation status of an organisation, or we'll have a specific planning discussion with them.

[67] **Jocelyn Davies:** So, I guess that the amendment that it would require approval has led then to this system, which sounds as if it's quite robust.

[68] **Mark Drakeford:** Yes, Chair. I think that's fair. I think I remember saying here that there always would be a system that we would want, but what the amendment did—what the change to the Bill did—was to put that on the surface of the Bill and therefore maybe did give it greater prominence and a greater sense of authority.

[69] **Jocelyn Davies**: Yes, okay. Ffred, back to you.

[70] **Alun Ffred Jones:** Pa gymorth ydych chi'n darparu i'r tri sefydliad sydd heb gynlluniau tair blynedd?

Alun Ffred Jones: What support do you provide to those three organisations that don't have three-year plans?

[71] **Mark Drakeford:** Wel, wrth gwrs, rŷm ni'n treial rhoi cymorth i bob asiantaeth sydd ddim wedi

Mark Drakeford: Well, of course, we do try to provide support to every agency that hasn't succeeded in

lwyddo i gael cynllun dros dair blynedd. Rwy'n gallu gofyn i Martin jest i esbonio'n union beth rŷm ni'n ei wneud gyda'r tri sydd gennym ni ar hyn o bryd.

having a three-year plan. I can ask Martin to explain exactly what we're doing with the three organisations that we have at present.

[72] **Mr Sollis:** Thank you, Minister. Obviously, with the three boards, one is in special measures. As part of the special measures issue with Betsi Cadwaladr, I think the Deputy Minister announced only last week the fact that we're actually putting in planning support to work with the board and putting people on the ground to help them devise the three-year plan, to make sure that they can get the right balance, going forward, in terms of sustainable services. So, that is a specific level of support that is probably higher than others.

[73] With the others—Hywel Dda, we have regular meetings with the accounting officer and with the team there, probably more regularly than any others that have got an approved plan status. We're going through that in fine detail with them; we're looking at the service issues there, we're looking at the safety issues and the quality issues, and looking to provide support where we can around individuals or around specific areas. For example, I know the delivery unit has gone into Hywel Dda to look at capacity and demand planning. In terms of financial support, we're looking to provide people into Hywel Dda to look at their financial planning aspect of that. So, all of that is a level of support that we provide to different organisations. I'll just give you two examples there, Chair, but special measures is a specific category and I think it's been recognised that we need to provide that extra support. We try to get organisations to identify and take it on themselves, rather than actually intervening. That is always better, because the ownership of the plan, the ownership of the developments of the issues, and the people who know best around the services, are going to be local. So, trying to get them to rise to the challenge is the first aspect and, where it doesn't happen, then we provide extra support, either on key areas or with key individuals.

[74] **Alun Ffred Jones:** Pa mor hyderus ydych chi y bydd y cyrff sydd heb gynlluniau tair blynedd yn gallu dod ymlaen â chynlluniau a chael cefnogaeth i gynlluniau tair blynedd?

Alun Ffred Jones: How confident are you that the organisations that don't have three-year plans in place will be able to bring forward plans and receive your support for three-year plans?

[75] **Mark Drakeford**: Well, Chair, one of the key commitments that I gave during the passage of the Bill—and I remember being questioned closely here on this by Simon Thomas and Paul Davies at the time—was that the ability to have a three-year plan was not going to be a barn door that every organisation would simply be able to walk through, regardless of the calibre of that plan.

[76] I'm just determined that we will sustain that approach to things, despite the—you know, you'll understand that sometimes there are political pressures to approve plans, to be able to say that every organisation in Wales is at that level. But I've been very keen to resist those sorts of blandishments, because I think it's got to be genuine. I say to health boards, 'The fact that you've got an approved plan this year is no guarantee that you'll get an approved plan next year; you've got to go on demonstrating that your plan is at the sort of level that merits that sort of approval.

[77] So, I was asked how confident I was that three organisations that don't have an approved plan this year will get one next year, and I suppose my answer is that I am variably confident. I don't feel, at this point, that it is likely that an organisation that is in special measures will have put itself in a position by the early part of next year that it will have an approvable three-year plan. The ambulance trust, by contrast, was actually quite close to having an approved plan this year. In the end, it didn't quite make it across the line but, as Martin said, we've been working with them and, in their case, I feel more confident that there will be a three-year approvable plan, but they will still have to demonstrate that in a credible way. Hywel Dda may be somewhere in between those two things. There's a new chief executive who is doing a very good job. Things are different—are better, definitely. Will he have got the organisation to a place that he will get a three-year plan approved for next year? The organisation is very keen and very committed, but they will have to demonstrate that they have met the tests that are there before you get approval.

[78] **Jocelyn Davies**: Okay, Ffred? Julie, shall we come to your questions?

[79] **Julie Morgan**: Yes, thank you. I wanted to ask more about the monitoring and escalation process, particularly in relation to Cardiff and the Vale, because we did discuss that at a previous committee. So, could you expand on how the monitoring and escalation process works, especially in the experience of Cardiff and the Vale, who have got a three-year plan in place but were put in enhanced monitoring arrangements?

[80] **Mark Drakeford:** Chair, I'll very briefly just tell you about the general, and then Andrew maybe will pick up the specific. In general, we have a new escalation and intervention arrangement in Wales, agreed in March 2014, partly as a result of work done at the Public Accounts Committee. It's a tripartite arrangement—the Welsh Government, Healthcare Inspectorate Wales and the Wales Audit Office meet together and review the status of all organisations in Wales. There are four levels of escalation. They meet twice a year, review all organisations and make recommendations to me as to whether an organisation is at the right level of escalation and monitoring, and organisations can move up and move down that ladder. Any one of the three organisations is able to call an extraordinary additional meeting during the year if they come across things in their routine work that they think everybody needs to get around the table to consider. That's how the general system works. Andrew will explain how it's been applied in the case of Cardiff.

[81] **Dr Goodall:** I said at the outset that the planning cycle comes as a package around making sure that we have accountability and escalations very clear. So, Cardiff, having noted that it had approved status from the very first year, is currently in enhanced monitoring status. So, that's level 2 out of the four areas that the Minister—

[82] **Julie Morgan:** It's still in it now, is it?

[83] **Dr Goodall:** And it remains in enhanced monitoring at this stage. That's the level that increases the level of frequency and contact with the organisation, with Welsh Government officials, through a variety of routine sources but actually other exceptional meetings as necessary. That will involve the team and the organisation more generally, but it actually gives a very close contact between me and the chief executive at this stage. They were confirmed to be in enhanced monitoring at the end of March 2015, so it was earlier this year after the routine escalation meeting with regulators at that stage. Actually, one of the factors that pushed them into that was a worry that they were not showing the traction and the delivery and the grip, perhaps, that was wanted around the areas that they'd highlighted within their plan. They had absolutely done the right things through their submissions about having an ambition for the organisation, some clear areas of focus and attention and actually manoeuvring their way through, but it was clear, certainly from the mid-year point, that perhaps not everything was performing to the level that we would have wished and expected.

[84] Actually, their end-of-year review process—and they remain in enhanced monitoring—did show us that, in that last six months of the financial year, they had been able to change a number of the areas of concern within the organisation, albeit that, at the end of the year, they still had a residual deficit and we needed to look at that in the round across the NHS Wales and the internal Welsh Government budget. Actually, they had made an improvement in their financial position to the end of the year but, in particular, they had been able to direct some proper focus around performance—so, an improvement in their unscheduled care system, particularly around long waits, around four hours, around ambulance response times. And, certainly, in their current status, as they've moved through the years, their position around improving waiting times, for example, and targeting—these issues have come through. So, we set out accountability letters for the organisation with some very clear conditions, and our view at this stage is that Cardiff, albeit with some underlying pressures still, do have a trajectory that shows that they are improving on a range of different fronts at this stage, but we keep it under very, very close review.

[85] **Julie Morgan:** At which point would they not be, would they cease to be, in enhanced—?

[86] **Dr Goodall:** I would expect at this stage that they will stay within the enhanced monitoring arrangements. There's been no reason to call forward any different process, and our routine meetings with the regulators will take place in December. Their mid-year review is actually taking place in two weeks' time, and what we'll do is use that as a routine part of the process to make our judgments on this, but we do see progress being made within Cardiff in that respect under the auspices of their approved plan.

[87] **Julie Morgan:** So that's—

[88] **Jocelyn Davies:** Hang on, Julie. Chris, did you want, on this point—?

[89] **Christine Chapman:** Yes, on this, but it's a general point, really, it's not just about Cardiff and the Vale. When you're looking at performance, obviously, I think sometimes there is a concern that performance can be monitored just against targets. How assured are you that you are looking at the sort of qualitative side of it so that it's not just, you know, that people are meeting targets but actually they're losing sight of the bigger picture?

Because I think that's a really important aspect.

[90] **Mark Drakeford:** Chair, one of the things I think we drew out during the original scrutiny process was that the integrated medium-term plans—because that's what we're talking about here—were a three-legged stool. They were about service—so, that's the quality dimensions. They're about workforce because, in some ways, the future of the workforce is the tool that is most directly in our own hands to make a difference to the future. And then they're about finance. It's about integrating those three things together. It's not about putting finance in the driving seat and saying, you know, 'Financial decisions are what drive this organisation.' It's about integrating the three dimensions to get a rounded picture of what a health board should be trying to achieve over that three-year period.

[91] **Jocelyn Davies:** Okay. Julie.

[92] **Julie Morgan:** Just a last question, really: which of the other NHS organisations do you have in enhanced monitoring?

[93] **Mark Drakeford:** Well, as I said, Julie, there are four levels. One organisation, Betsi Cadwaladr, is at the fourth level—the special measures. Then, there are three other organisations at level 2, and they are Hywel Dda, the Welsh ambulance trust and Abertawe Bro Morgannwg. Everybody else is at level 1.

[94] **Julie Morgan:** Right, thank you.

[95] **Jocelyn Davies:** Okay. Nick, shall we come to your questions?

[96] **Nick Ramsay:** Thanks, Chair. As the Act stands, there is a risk that the benefits of financial flexibility will be reduced after the second year of a three-year plan. What flexibility do you think can be built into the system in terms of a tolerated range on meeting rolling three-year targets?

[97] **Mark Drakeford:** Chair, I think there are two answers to that question, and then others will be better placed to do some of the detail. First of all, I think it is important to say that, from the beginning, this was constructed as a rolling programme. So, there is no inherent reason why flexibility becomes squeezed out as the system rolls on, because you're always in the start of a new three-year cycle every year. So, I think the system is designed to address part of the point that Nick has made. The bigger question is the second one,

which is how much flexibility we can allow in the system. I remember saying here that I have to take a cautious approach to that because any flexibility we are able to offer local health boards can only be offered within the totality of the main expenditure group that I have to manage because the MEG still has to balance at the end of the year. So, my ability to allow LHBs flexibility depends entirely on how much room for manoeuvre we have within the whole of the health budget. In the financial circumstances we are in as a Welsh Government, with a reducing quantum year after year, there is tolerance and we have afforded it during these early parts of the new regime, but it's going to be constrained during a period when austerity is biting so hard. We can't allow LHBs flexibility that then strikes against our ability to balance the MEG in its totality.

[98] **Nick Ramsay:** So, my follow-up question is: do you think there is scope for local health boards to carry forward unplanned surpluses and deficits?

[99] **Mark Drakeford:** I am reluctant to open the Pandora's box of unplanned surpluses and deficits. Planned surpluses and deficits are what this regime is about. It's about agreeing with health boards when they need to overspend in year 1 to make sensible investment decisions that then release revenue in years 2 and 3 or, sometimes, underspend in year 1 because there's a big project that they want to be able to take forward in year 2. Planned deficits, I think, are firmly within the sight of three-year plans. I wouldn't want the idea to get around in the health service that you can rack up unplanned surpluses or deficits—

09:45

[100] **Nick Ramsay:** Just between these four walls. [*Laughter.*]

[101] **Jocelyn Davies:** Well, it is a message that's gone out loud and clear, but perhaps not loud and clear enough in the—

[102] **Nick Ramsay:** On the issue of the planned surpluses and deficits, though, they must themselves be within certain parameters, mustn't they, otherwise you could have the planned areas just expanding to a point where it's uncontrolled.

[103] **Mark Drakeford:** That's absolutely right, Chair, and I face the fact that, because of the limitations of our budget as a whole, sometimes, we will have

to deny even planned flexibility to one health board because another health board's plan has got a higher priority, even when the second health board's plan might be a plan we would want to approve. All this can only be done within the overall limits of the budget.

[104] **Jocelyn Davies**: Before I call Peter in, Minister, I know you've got other commitments in your diary. I'm happy to continue just with your officials if you have to go.

[105] **Mark Drakeford**: I could manage to stay until 10 a.m., Chair, if that was helpful, but then I will have to go.

[106] **Jocelyn Davies**: Okay, and then, if we've not finished, we'll continue with the officials—

[107] **Mark Drakeford**: By all means.

[108] **Jocelyn Davies**: —and you'll go.

[109] **Mark Drakeford**: Thank you.

[110] **Jocelyn Davies**: Have you finished, Nick?

[111] **Nick Ramsay**: No, I've got one more question. Capital funding is critical to engineering service change. How is capital funding agreed within the three-year planning system?

[112] **Mark Drakeford**: In exactly the same way, Chair, as revenue is. The three-year plan has to identify the capital expenditure that the board intends to carry out. It's a mixture, as you know, of discretionary capital—we give about a quarter of the whole budget out directly to boards for them to make decisions on. Where they have bigger plans, they have to include those in their three-year plans, and their capital planning is tested against criteria in the same way as revenue is. These days, I'm having to say to health boards that I'm only likely to be able to approve capital schemes if they do such things as genuinely driving service improvement and releasing revenue as a consequence of capital investment. So, it's part of the same three-year planning regime with specific criteria applied to capital planning.

[113] **Jocelyn Davies**: Okay. Yes, Ffred.

[114] **Alun Ffred Jones**: Do all of these boards have estate strategies—planned estate strategies?

[115] **Dr Goodall**: Yes, every board has their own service strategies, estate strategies, in place. About a quarter of the capital budget that we hold for the NHS side gets allocated to individual organisations for their discretionary use on a local basis. Of course, they can invest in some of those, but those of a material value will obviously come through the Welsh Government approval process. But, yes, every organisation in Wales, as part of this plan, does have a focus on this. I think it's important to say that, although the planning cycle is on a three-year basis, of course you would expect organisations to be looking forward and, often, plans can be looking five, even 10 years into the future, and we are also very focused on that as well.

[116] **Jocelyn Davies**: Okay. Peter, shall we come to your questions?

[117] **Peter Black**: Yes, thanks, Chair. The current consultation 'Our Health, Our Health Service' does consider the case for borrowing powers for health boards. If such powers were to be granted, do you have plans for how this could be incorporated into the integrated three-year plans process?

[118] **Mark Drakeford**: Chair, I am reluctant to anticipate overmuch what the result of the Green Paper consultation would be. If there's a model that I imagine anybody doing this job would look to if we were to give local health boards borrowing powers, it is the way that we negotiate borrowing powers with trusts, who have those powers already in Wales. So, Velindre, for example, has made use of its borrowing powers and, as you will know, we are in the middle of very exciting negotiations with Velindre about innovative funding models that we will be able to apply to creating a new Velindre. The same rules would apply, I imagine, to an LHB as anybody else. I do remember Mike's contribution around this point last time I was here, which was, you know, you can only borrow money if you can pay it back. So, that would apply to LHBs, but, in the future, when capital is going to be so scarce, I imagine anybody sitting in this chair would want to see ways in which prudent borrowing could be used for those longer term purposes. It can't be for just here-and-now consumption. It would have to be for planned—

[119] **Peter Black**: But the system is flexible enough to be able to accommodate that, if that were to happen?

[120] **Mark Drakeford**: The rules would have to be changed because, at the

moment, health boards can't borrow, so we would have to bring legislation forward to give them that capacity and, as I say, if we've got a model in mind, it will be the trust model as we've operated it.

[121] **Peter Black**: Would their borrowing count against the limit we have in the Wales Act?

[122] **Mark Drakeford**: I believe it would.

[123] **Peter Black**: It would, yes. Okay, fair enough—

[124] **Jocelyn Davies**: Before you go on, Mike was it on this particular—

[125] **Mike Hedges**: That was my point—

[126] **Jocelyn Davies**: That was your point, right. Okay. The borrowing powers were an issue raised during the passage of the Bill. I think it was an amendment. I think it might have been Paul Davies. I'm not sure—

[127] **Mark Drakeford**: It was. You'll remember, Chair, that I said at the time that the reason we weren't able to take it forward then was because we were using the accelerated procedure and I'd given a commitment to the Business Committee that this was a one-purpose Bill. It was a one-and-a-half-page Bill, and I didn't feel it was right to extend its scope, given the fact that there had been no Stage 1 opportunity to test the whole issue.

[128] **Peter Black**: Yes.

[129] **Mark Drakeford**: But that's why we brought it forward in the Green Paper—because the case for looking at it was very well made.

[130] **Jocelyn Davies**: Peter, back to you.

[131] **Peter Black**: Is there a danger that, if you have this financial flexibility, that could increase the risk of unsustainable debts?

[132] **Mark Drakeford**: If it was not done properly, I think that risk would be very real.

[133] **Peter Black**: Thank you.

[134] **Jocelyn Davies**: Yes, because borrowing is just spending money at a different moment than you would have anticipated originally. Okay then. Chris, shall we come to your questions?

[135] **Christine Chapman**: Okay. I think my first question has been answered regarding what assessment you've made about the impact and effectiveness of the Act. We've discussed that, I'd say. Have you made an estimate or tracked the additional costs imposed by the Act, and how does this compare to the original estimates in the original regulatory impact assessment?

[136] **Mark Drakeford**: Well, it is early days, Chair, as we've only had one year of a three-year cycle. Members here may remember that the costs of the Bill compared to the option of doing nothing, which is what the regulatory impact assessment rehearses, were relatively marginal. I think we know now that the costs to the Welsh Government are turning out to be less—about half of what was anticipated in the original RIA—partly because we have used our own internal resources for the planning and monitoring of the Act to a greater extent than maybe we first anticipated. The only other costs identified in the RIA would be costs for the Wales Audit Office, and I'm afraid in the time that we had available we've not been able to get a proper understanding from them as to whether their costs have increased in line with the RIA. But it's important to say that probably the greater part of those costs would be incurred in any case at the end of the third year of the three-year cycle—

[137] **Christine Chapman**: Sorry, can I clarify this? So, there is no additional funding, then, to the Wales Audit Office for this procedure.

[138] **Mark Drakeford**: The RIA did identify additional costs that could be incurred by the Wales Audit Office. Our belief is that most of those, if they do occur, and it's an 'if' given our experience because our costs have not materialised to the extent that the RIA anticipated—. If they do materialise, they won't have materialised yet, only halfway through the first three-year cycle.

[139] **Christine Chapman**: Okay, thanks.

[140] **Jocelyn Davies**: Okay. Jenny, shall we come to your questions?

[141] **Jenny Rathbone**: I was going to ask you a question about the evidence of the benefits that the Act and the three-year planning process have

achieved, but I feel that you have given ample evidence in your answers already, although it's an opportunity for you to add anything if you wish. My other question, and you might want to wrap these up together, is: there have been additional sums of money given after the initial budgets had been approved—. In September 2014, there was a further £200 million identified, and then there was a particular pay award for nursing staff, which was covered by £18.9 million, and then there was an additional £40 million for dealing with winter pressures, announced in January. I just wondered how you are able to—. Whilst, obviously, these sums of money are welcome, does it in any way undermine the strategic planning process that you've put in place and possibly tolerating unplanned deficits?

[142] **Mark Drakeford:** Chair, I'll have one go and then others will have things to say. In terms of evidence of success, maybe the one thing I haven't mentioned that I think is emerging as success is that, as we have organisations that provide plans that meet the threshold and then, by the process of monitoring, demonstrate that they are able to deliver the plan that has been approved, we have a sense of some trusted organisations emerging here, where we are able to give them freedoms to do things that other organisations that are not in that position would not have. So, that sense of differentiation is emerging. So, we had some extra money we were able to provide in capital as discretionary capital last year. For organisations that were emerging as trusted and delivering organisations, we simply said to them, 'Here is your share of it. You make the decisions; you don't need to be telling us'. To organisations that weren't in that position, we said, 'Here is money that we are earmarking for you, but we will need to see your plans before we give it to you'. So, I think that sense of earned autonomy, as you call it, is part of the benefits of the Act.

[143] In relation to Jenny's second question, my own view is that having a three-year approved plan actually makes it easier to allocate any additional sums of money that might become available in an informed way, because if you do have money—for example, we had £40 million for primary care this year as a result of last year's autumn statement—because we've got organisations with approved plans and we know those organisations have got solid ideas for how their primary care service is going to be developed in the future, we're able to make better decisions with any additional money. I think it helps, rather than hinders, the process that you outlined.

[144] **Dr Goodall:** I think it allows us to have a more mature discussion with those individual organisations, so should there be flexibility or a wish to

support some of their intentions, organisations can talk to us about whether they can pull forward some of their year 2 proposals and make them an earlier impact for the local population. Again, as the Minister said, some of the organisations that we have confidence in have been able to demonstrate that, and we've put in funding support around them.

[145] **Jenny Rathbone**: Thank you.

[146] **Jocelyn Davies**: Nick, you had a supplementary. Minister, I understand you have to go.

[147] **Mark Drakeford**: Excuse me. Thank you very much indeed.

[148] **Jocelyn Davies**: Nick, you had a supplementary on this.

[149] **Nick Ramsay**: Yes, just a very quick question on the capital spend. In south-east Wales, your old neck of the woods, is the Gwent Clinical Futures care programme still on track?

[150] **Dr Goodall**: Where we stand on that: we had a requirement on the health board to be submitting their plans for the end of October, so that is the greater detail of the business case. We obviously have to go through the very formal processes here, and I can confirm that the health board has submitted the business case. That's now currently being reviewed by officials, in line with the normal capital process at this stage. We've had a lot of contact with the organisation over the recent months, as they've been continuing to develop the plans and the detail that's available. They've been permitted, as you know, to move ahead with a number of the enabling mechanisms for that proposal, but it's now with Welsh Government and being reviewed through our own proper processes.

[151] **Jocelyn Davies**: It seems to have been many years in the gestation—

[152] **Nick Ramsay**: Well, it has been. Ten years now, I think.

[153] **Jocelyn Davies**: Mike, did you want to come in on this—not on that particular point, but on Jenny's question? And then we'll come back to Jenny, if she's got any more.

[154] **Mike Hedges**: Yes. We also have an alternative source of funding, which is invest-to-save, and which has spent very large sums of money.

When it's completely paid back, which is meant to be over three years, sometimes it drifts to five, is that money then coming back into the system or is it a pretend saving?

[155] **Dr Goodall:** No, there's a genuine saving around these issues. The invest-to-save process has to be tracked and has to be monitored. Clearly, as every scheme embarks, there may be some schemes that may struggle to deliver some aspects of it, but the general experience on invest-to-save has been very positive. I do think there's a principle to set for the NHS more broadly and, perhaps, for the individual organisations. You know, we do have organisations of size and scale. You have health boards that have got budgets of over £1 billion. I think that if you're able to have an invest-to-save proposal and you can deliver those savings within 12 months, we would rather that they started actually delivering their own local targets in this area. But we have been pleased, actually, that there's been a very good level of support for the NHS in Wales through the Welsh Government's invest-to-save scheme process, and we have been able to show success. One of the tricks will be about rolling those out more broadly.

[156] **Jocelyn Davies:** As part of the three-year plans, then, the invest-to-save, they have to show in that plan the payback. It's part of your scrutiny of it.

[157] **Mr Sollis:** It has to be repaid. We have to provide the money back to the finance Minister, who then reinvests it back in services.

[158] **Nick Ramsay:** It's a big concern of Mike Hedges's.

[159] **Mike Hedges:** Actually, it wasn't the paying back. Mine was the ongoing savings actually coming through as well. Yes, you can do all sorts of sleights of hand—accountants are good at these things—in order to show savings and make the payback over a period of time, over the three years or four years, it's the fact that that now should be shown as a saving in subsequent years and every subsequent year.

10:00

[160] **Dr Goodall:** We do have to have a focus around recurrent levels of savings. Obviously, organisations will always look at some in-year issues. I think an independent report that validated, actually, that there were real savings to be made in the system was the Nuffield review, when it came out.

What it showed us is that, actually, a level of savings around the order of £1 billion had been delivered within the NHS that were beyond just, sort of, notional savings on the table.

[161] **Jocelyn Davies**: Yes, but I think Mike's point is that the invest-to-save, in itself, that project, must result in the savings that pay back, and you're satisfied that that is the case.

[162] **Mr Sollis**: It does, Chair, and what we try to do, more importantly, is to share the messages about what has succeeded so that the savings are shared with other health boards, so that then they can look to either invest themselves, as Andrew has said, or that we try to get others to adopt a slightly different approach in terms of some of the savings. But the lessons learned from that are very, very important, and monitoring the savings in there, that they're real, is key.

[163] **Jocelyn Davies**: Well, we know the lessons are important, but whether anybody learns from others' good practice, I'm not sure. Jenny, do you want to come back in?

[164] **Jenny Rathbone**: I just wanted to pick up on the extra £40 million that the Minister mentioned for primary care and really just ask you how you are ensuring that, as ever, the poor relation in terms of clout—both financially and the voice on the board, often—in your detailed three-year planning with boards, namely primary care, is getting the resources it deserves, as there's always a tendency for hospitals to gobble up all the resources. I specifically recall that the percentage of money dedicated to primary care has actually gone down. It's often quoted, and GPs often say, 'Look, it's gone down to 7 per cent and it used to be 10 per cent'. So, I wonder if you can just respond to that.

[165] **Dr Goodall**: I think it's about making it very clear within the planning framework. I said earlier that we've tried to keep the planning guidance quite consistent so that there is a beat about organisations making progress and not just inventing new approaches for them. But the one area that we've highlighted particularly for the refreshed guidance has been around primary care being a real area where we are testing the shift. The framework actually sets out what we would feel to be the success criteria for organisations that are actually addressing primary care. The funding that Welsh Government has provided does give us an opportunity to be very focused on its use and, as an example, the Minister has been very clear about wanting to support the

cluster model in Wales. This is about breaking up the populations into 30,000 or 50,000 population groups, 64 clusters, and actually getting the money right through to the individual clusters, with an individual allocation. That allows the clinical teams led by the GPs to really make some very clear decisions about what their local population health needs are and to actually use it to their advantage. We are very carefully monitoring the use of that money being made during this year, which is the first year that that money's been available. But the process, and the detail of the planning team and how they review, that's where you get confidence about where the individual organisations are going.

[166] I actually thought we had a bit of a breakthrough this year when, as organisations were trying to put in their proper submissions, we were looking through the plans, but one health board in Wales actually said, 'Look, we could end up just writing to each other on many occasions; just tell me which organisation is leading the way on this in Wales. Let's learn from their submissions, and we'll see whether we can apply it locally.' I thought that was a good sign of maturity starting to come through the planning cycle, not least on primary care.

[167] **Jenny Rathbone**: Okay, although the particular anxiety coming from some of my constituency GPs is that there's an attempt to get services that don't need to be in hospitals out into primary care; how do you get the resources following that relocation?

[168] **Dr Goodall**: Yes, that's a difficult issue, because it won't just be about new moneys that have been announced, which is what the £14 million constitutes; that's the real challenge to our traditional model of service. But I think we are making some progress there as well. It's quite clear, again, through the plans and the delivery plans that Welsh Government has put in place as well around individual conditions that we are starting to see progress on some individual areas. So, areas like diabetes management, for example, doesn't need to be located in that specialist world, although people will need access to hospitals at times. What we're asking health boards to do through their plans is to show how they are shifting the resources and the attention, and I think in the best examples, they've been able to demonstrate how the hospital clinicians have actually changed their environment. They see themselves as more reaching out into the community on a much stronger basis—whether it's around respiratory services or diabetes. But we are tracking those mechanisms and, again, it's one of the success criteria that we put within the planning framework.

[169] **Jenny Rathbone:** Okay, so which health board is the leading-edge one?

[170] **Dr Goodall:** Around primary care development at this stage?

[171] **Jenny Rathbone:** Yes.

[172] **Dr Goodall:** We see that ABMU have put in some very strong proposals. We see that Aneurin Bevan have made pretty good progress on their cluster model, and also Cwm Taf are coming in with some very good innovative work at this stage. But, actually, the others are catching up now very quickly; there's been a lot of sharing about this.

[173] **Jocelyn Davies:** Okay. Ffred, did you have a supplementary?

[174] **Alun Ffred Jones:** Yes. This percentage decrease in resources going to primary care—is that planned?

[175] **Dr Goodall:** It's just the nature of the expansion of the overall budget. Martin, you might want to describe some of the technical aspects.

[176] **Mr Sollis:** It isn't planned; that was a past trend. The issue for us now is to try to get the redirection of resources, and that's where the £40 million and other things are being directed.

[177] **Jocelyn Davies:** We've run out of time; we've run over, actually, but I think it's been a very useful session. At least it's given us a good idea of how the legislation is bedding in and how it's being used. Thank you very much.

10:06

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cynnig: *Motion:*

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y *that the committee resolves to exclude the public from the*

cyfarfod a'r cyfarfod ar 19 Tachwedd yn unol â Rheol Sefydlog 17.42(vi).

remainder of the meeting and the meeting on 19 November in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[178] **Jocelyn Davies:** So, I think we should move to private session now under 17.42 for the remainder of this meeting and for the whole of the meeting of 19 November. Okay, thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:06.
The public part of the meeting ended at 10:06.