Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

DRAFFT - DRAFT

Dydd Mawrth, 27 Tachwedd 2012
Tuesday, 27 November 2012

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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. Mae hon yn fersiwn ddrafft o'r cofnod. Cyhoeddir fersiwn derfynol ymhen pum diwrnod gwaith.

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. This is a draft version of the record. The final version will be published within five working days.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
Jocelyn Davies	Plaid Cymru The Party of Wales
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

Eraill yn bresennol
Others in attendance

Helen Birtwhistle	Cyfarwyddwr, Conffederasiwn GIG Cymru Director, Welsh NHS Confederation
Gillian Body	Archwilydd Cyffredinol Cynorthwyol, Swyddfa Archwilio Cymru Assistant Auditor General, Wales Audit Office
Alan Brace	Cyfarwyddwr Cyllid a Chaffael, Bwrdd Iechyd Lleol Aneurin Bevan Director of Finance and Procurement, Aneurin Bevan Local Health Board
Kevin Flynn	Cyfarwyddwyr Cyflawni a Dirprwy Brif Weithredwr GIG Cymru Director of Delivery and Deputy Chief Executive of NHS Wales
Mark Jeffs	Swyddfa Archwilio Cymru Wales Audit Office
David Sissling	Prif Weithredwr GIG Cymru a Chyfarwyddwr Cyffredinol, Iechyd, Gwasanaethau Cymdeithasol a Phlant—Llywodraeth Cymru Chief Executive of NHS Wales and Director General of Health, Social Services and Children—Welsh Government

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

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

Dechreuodd y cyfarfod am 9.02 a.m.
The meeting began at 9.02 a.m.

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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.

[2] I remind everybody to switch off their mobile phones, BlackBerrys and pagers, because these can interfere with the broadcasting and other sound equipment. For those who require it, the translation is available on channel 1 of the headsets, and the amplification is on channel 0. As per usual, I remind people that the National Assembly for Wales is a bilingual institution, and Members and witnesses should feel free to contribute to the meeting in either Welsh or English as they see fit.

[3] We have not had any apologies this morning. We have a full house, so we will move on to item 2 on our agenda.

Cyllid Iechyd—Tystiolaeth gan Lywodraeth Cymru
Health Finances—Evidence from the Welsh Government

[4] **Darren Millar:** We are delighted to be able to welcome to the table today David Sissling, who is director general for health, social services and children in the Welsh Government, Kevin Flynn, director of delivery and deputy chief executive of NHS Wales, and Alan Brace, interim director of finance of Aneurin Bevan Local Health Board. Welcome to you all.

[5] Thank you very much for the paper, which has been circulated to Members. Would you like to make a few opening remarks on that before we go into the questions proper?

[6] **Mr Sissling:** Yes. Thank you for the opportunity to discuss NHS finances, and thanks to the Wales Audit Office for its very helpful analysis, commentary and recommendations in various reports. In my opening comments, I suppose that I just want to emphasise two things, the first being progress, and the second, challenge. I think that that is a fair representation of where health and the NHS are at the moment.

[7] On progress, we are seeing better planning and better financial management, both centrally and locally. I think it fair to say that we are seeing an enhanced grip across the service at board level, with more ownership of financial issues within strengthened accountability arrangements and improved financial performance and outturn last year, which has carried through into this year. We are seeing positive movement in non-financial delivery, because it is important at all stages that we look at money alongside matters such as performance, quality and safety. We should not look at finance alone. There is a whole series of issues to make sure that the service is sustainable, and part of that relates to technical financial matters, but it is also about new models of care and new service delivery arrangements, all enabling the ultimate goal of ensuring a better patient experience, the better use of resources, and better outcomes.

[8] Challenge, alongside progress, has taken us through to this year, in which we are continuing to seek to drive up quality and patient experience at a time of financial constraint. This year, interestingly, we are seeing some very significant, increased demand, driven by the demography patterns of the population across Wales. Our Minister is absolutely clear that the requirement is to maintain quality and focus on delivery and that there is a need for enhanced good financial management at Welsh Government level and across all parts of the NHS. Finally, looking ahead, it is fair to say that the challenges in respect of revenue or capital will

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not diminish. We will continue to face significant challenges, and our response is based on new strengthened planning arrangements, a new financial regime, enhanced capabilities, improved systems, new service models, greater clinical engagement and, of course, a continuing obsessive emphasis on quality.

[9] **Darren Millar:** We will return to many of those issues as we go through our questions. We have now had two reports from the Wales Audit Office, both setting out very clearly the enormous challenge that the NHS in Wales faces with regard to its finances and trying to deliver service change in order to meet that financial challenge. They seem to fly in the face of the assurances that you have given on the ability of the NHS to meet that financial challenge by the end of the financial year. How do you reconcile those two? Is this not keeping you awake at night?

[10] **Mr Sissling:** No, not at all, but that is not to say that the challenge is not there. This is a difficult year with a difficult set of challenges. The issue for the NHS is to recognise the statutory responsibility to break even—and we need to get into the frame of mind that it is not 'if' but 'how' we break even, working with health boards and trusts while accepting that Welsh Government has a role in overseeing delivery and, at times, providing support to the system at a system level and an organisational level. To answer your question, no, I do not think that there is a problem in reconciling these positions. We very much concur with the analysis that the Wales Audit Office has undertaken of the scale of the in-year pressure and the scale of the pressure that remains with us to the end of the year. Our task is to move beyond the diagnoses and to ensure that we have responsive plans in place to allow us to break even at the end of the year, with the maintenance of high quality and improved performance.

[11] **Darren Millar:** So, you agree with the analysis of the Wales Audit Office that it is most likely that the NHS will be £70 million short at the end of the financial year.

[12] **Mr Sissling:** We agree, first, because the Wales Audit Office's analysis is based very directly on the work of the health boards and trusts, and it has basically compiled and collated that information. In our assessment, which we have undertaken particularly rigorously as the year has gone on, we have focused at the half-year point on a series of interactions with the health boards to test out whether it is the most likely scenario or whether it is at either end of the spectrum, and we concur very much that it is most likely that it is a realistic and reasonable assessment of the scale of the pressure in the NHS.

[13] **Darren Millar:** But just a week ago, you were telling us that the NHS was going to break even. Now, you are accepting that it is likely to be £70 million short.

[14] **Mr Sissling:** No, we are accepting that that is the level of pressure. Pressure means that we have to respond, and we always knew that there would be pressure on the system this year. Any analysis would have indicated that. Part of our role in looking at the pressure and, in a sense, the risk associated with the pressure is to ensure that we have strategies and plans to allow that risk to be managed, to ensure that, if necessary, we can provide the right kind of intervention and support to ensure that the NHS will break even and have an appropriate year-end position. There are two parts to this: first, there is the scale of the problem, and we concur on that; secondly, there is the response to the problem, which we might explore in the course of this discussion.

[15] **Darren Millar:** Yes, and we will be exploring that. Of course, we are not just interested in the current financial year, but in future years, and I know that you are, too, in wanting to put the NHS on a sustainable footing. How do you see the pressure on NHS finances in the medium term—two to three years down the line? Will the finances continue to decline, or are you expecting them to level off or increase?

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[16] **Mr Sissling:** At the moment, we think that it would be wise to accept that there will be continuing financial constraint. That is common to all parts of the public service, and not just the NHS. So, with more extended planning, we are looking at a number of scenarios, but we would be wise to consider options that continue to involve very significant financial constraints. Clearly, the role of the NHS at any point is to rise to the challenge and deliver within the means provided to it through ministerial decisions.

[17] **Darren Millar:** In the UK context, everyone accepts that the NHS in Wales is getting a worse settlement than the NHS in other parts of the United Kingdom and is facing the biggest financial challenge in terms of the level of decrease in funding in real terms. How is that having an impact on the way we do things in Wales compared to how they are done elsewhere in the UK? Are you noticing a very different approach to such things as service reconfiguration or to meeting that financial challenge in Wales?

[18] **Mr Sissling:** I think that comparisons with other parts of the UK should always be treated with a degree of caution. I say that having worked in Wales now for four years and previously in Northern Ireland and in England for many years. I think that we need to be quite careful in forming judgments. From my perspective, based on personal experience, Wales is in a very good position in terms of the resilience of its system and the developing maturity of its system and our ability to respond not just to financial challenges, but to the challenge of driving up quality by using all of these very important capabilities to deliver integrated care across primary, community and secondary care, and to do so with pace and urgency, to mobilise clinical leadership to support that, and to make sure that we are looking at pathways of care and that we focus on prevention. Our system is perfectly designed to allow us to do that. We also have the advantage of organisational stability, which, as you know, some parts of the UK do not have. Some are going through some very traumatic organisational change. I think that it is to Wales's benefit that we can work with real purpose in an integrated way. We do not have to transact change. We are not working in a market situation, which, at the moment, I think, is a huge benefit. We can move from problem to opportunity to solution to action with real pace, rigour and determination.

[19] **Darren Millar:** Real pace. We will talk about re-organisation and service change in a few moments, but first I call on Jocelyn.

[20] **Jocelyn Davies:** Your paper states that there was a high level of risk associated with the LHB delivering on the financial plans that it had submitted at the beginning of the year. Was that also the case last year, that there was a high level of risk?

[21] **Mr Sissling:** Last year?

[22] **Jocelyn Davies:** Yes. They submitted their plans at the beginning of the year. I see the comment in your paper that there was a high level of risk associated with them delivering on the plans that they had submitted at the beginning of the year. Would you say that it was the same last year?

[23] **Mr Sissling:** I think that there was risk last year. I suspect that there will be risk every year. Part of our role, and that of the health boards, is to assess the risk and to put mitigating action in place. I think that it is a reasonable expectation, in terms of planning, good management and good leadership, that we would assume that there will be risk and that we take action to understand that risk and anticipate the risks materialising.

[24] **Jocelyn Davies:** Yes. Well, as I say, you mention in your paper there being a high level of risk when the local health boards submitted their plans this year. Do you agree that there was a high level of risk when they submitted their plans at the beginning of last year?

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That leads on to my next question.

[25] **Mr Sissling:** Whether it is more or less, there was certainly risk last year, at the beginning of 2011-12.

[26] **Jocelyn Davies:** But you do not want to say that there was a high level of risk. Okay. That is fair enough. Given that there were these real-terms reductions that the Chair mentioned earlier, was the message that the recurrent funding allocated in October 2011 was to put the NHS on a more sustainable footing too optimistic, and did it, in itself, risk understating the scale of the challenge?

[27] **Mr Sissling:** No. I think that it was a really critical movement. The previous pattern had been associated with non-recurrent moneys being made available towards the very end of the year. What we were able to do, and what our Minister and the Cabinet secured, was a movement from non-recurrent to recurrent funding for her overall budget. That puts it on a much more stable, secure ground. It is a much better basis to manage risk, actually, that we know what our means are, and the challenge to us is to live within our means without the expectation of any additional support from outside the health main expenditure group.

[28] On whether it was understated, I think that it would be difficult at this stage to say that the scale of the financial challenge facing the NHS is not fully recognised and appreciated. People are very familiar with it within all parts of the NHS and within the Welsh Government, so, the scale of the challenge has never been under-emphasised.

9.15 a.m.

[29] **Jocelyn Davies:** So, you probably do not agree with the auditor general's comment that this sent a mixed message—that historic mixed message of, 'You have to manage within your means', but then there is this extra money. Do you not agree with his comment that that was a mixed message?

[30] **Mr Sissling:** I did not read that into his comments. As I recall, he thought that there was a possibility of there being a mixed message. I think that the message that went through last year was very clear: that we had moved from the position that I described and which had existed previously to the provision of recurrent money. That was a very clear, unambiguous message that health boards and trusts had to live within their means. That was reinforced at the year-end, when, as you know, we had to provide a small amount of brokerage to a small number of organisations. That was not the provision of money without any conditions attached, and it really did emphasise the need for accountability at organisational level through to the Minister for health. Therefore, I think that the message was a very clear one: it was a message based on delivery and accountability, and it was a break from the previous regime and how things had worked previously. The evidence for that is what we hear from the health boards, which are now very clear about the importance of delivering.

[31] **Jocelyn Davies:** We have all heard the very clear messages in years gone by, 'This is the last time that you will be bailed out', on several occasions. How did you calculate the level of funding that LHBs would receive? There is a recurrent uplift that is identical in five of the seven. Therefore, how did you calculate how much each one was going to get? Given that they were all in different circumstances, why did five get exactly the same amount of money?

[32] **Mr Sissling:** I might ask Alan to comment on this. It was very much an approach that was based on our assessment of risk. Our assessment and understanding was of the position of each health board, and to ensure that we adopted an approach that was based on the risk that was evident as the months of that year unfolded. Do you want to add to that, Alan?

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[33] **Jocelyn Davies:** So, it is just a complete coincidence that five of them had exactly the same amount? Their calculation of risk, or whatever, was identical, was it?

[34] **Mr Brace:** No. I think that two health boards were in a slightly different position. Hywel Dda LHB, for example, was on a tapering support package, and Powys LHB is a very different health board from the larger health boards. However, when the plans and the level of demand on the system were being assessed, it was felt that an element of consistency was needed in that. Given the level of risk that each health board was carrying, it was felt that that was an appropriate basis on which to broadly treat them the same, but, for each, there was a further stretch that they needed to make to get to break-even by the year-end. So, it was not addressing all of their issues; it was trying to put them on a fairly stable platform recurrently to give them the opportunity to deliver by the year-end.

[35] **Jocelyn Davies:** I see. So, it was not that you had a sort of overall sum, a special case for two, and then just divided the rest equally between the remaining five.

[36] **Mr Brace:** No.

[37] **Jocelyn Davies:** So, a calculation was done in each case in terms of risk, and it just happened to be the same sum—it was just a coincidence, was it?

[38] **Mr Brace:** Increasingly, this system allows us to have close dialogue with the health boards, through their planning phase, and also in month-on-month delivery. That gives us a real sense of what risks each health board is trying to manage, and we can track performance against that. However, it allows us to make more sensible decisions when it comes to allocating funding.

[39] **Jocelyn Davies:** Okay. Thank you.

[40] **Darren Millar:** Do you want to come in on this, Aled?

[41] **Aled Roberts:** Yes. In these very sophisticated arrangements that you have, which just led to five of the seven boards getting exactly the same amount of money, did you assess the impact of giving a large board the same amount of money as other boards, as far as front-line service delivery was concerned? Did you understand that there would be community hospitals closed for three or four months at a time for the year, with no service provided in that area?

[42] **Mr Sissling:** I do not think that that was a direct consequence of the decisions that we took. I can understand the question about why it was £17 million—I think that that was the figure—that was given to five of the health boards. By way of further context, it is fair to say that all health boards, at that point, had they been taking forward their own cases, would probably have said that they felt that they required more than that at that point. So, in every case, we set stretching targets. We could argue that one is £17.9 million, and that one is £16.8 million. However, there was a point at which we felt that it seemed to be a challenge that was reasonably common to all health boards. Health boards are of different sizes and all have different characteristics, and we came to the conclusion that it seemed reasonable to give them a similar ask in terms of what they had to provide from the point at which we made the decision to the end of the year. On the consequence of that and whether it led to any reduction in services, I do not think it did. That was not the reason for ceasing services in some community hospitals for periods of time in one or two health boards: those were decisions based on staffing.

[43] **Jenny Rathbone:** Given that the ‘most likely’ forecast from the auditor general is of

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an end-of-year deficit of around £70 million, could you enlighten us as to how you are going to manage it? Are you going to leave health boards to sort out their own problems, or are you going to provide additional funding? If so, what conditions might you attach to that additional funding?

[44] **Mr Sissling:** I should just make the point that it is the forecasts of the health boards; it is something that the Wales Audit Office has collated, not its forecast. The WAO has basically played it back. It is a forecast that the health boards are making that, in a sense, has been reinforced and confirmed by the Wales Audit Office, based on its analysis. We also think that that it is a reasonable basis for planning for the rest of the year; we see that 'most likely' figure as a reasonable basis on which to plan. The knowledge that there was growing financial pressure in the system has been with us as the months have unfolded, so it was not as though, at month six, we suddenly discovered a developing sense of pressure. It was for that reason that the Minister asked me to undertake a review—which I have now completed and which is with the Minister—which has recommendations for her consideration. I will give you some background and context, because I think that it is quite a critical moment and important for me to advise you of some of the aspects in relation to that review. Clearly, it would be inappropriate for me to go into the detail, because it is with the Minister for consideration. I believe that she will make an announcement next week about her position on the various recommendations.

[45] The context is one of pressure—financial and non-financial—and, also, going back to earlier questions, of a requirement for the health sector, the NHS, to live within its means. That is a reasonable task and we have taken that forward within this review. The context was also one of an understanding that it would be incontrovertibly good financial management to recognise the risk and establish a contingency, which, in my evidence paper, I shared with this committee. At the beginning of the year, we established a contingency in the order of 1%; I think that we would have been criticised if we had not done so. So, we go into this year with a contingency, anticipating pressure and the possibility that circumstances may arise in which it would be wise to deploy that contingency.

[46] The review involved an assessment of data—financial and non-financial information. It is important that we look at issues of performance, quality and outcomes, as well as the financial information. It has involved clear, direct discussions with each of the health boards and trusts. We need to get beyond the numbers to understand the position from within the health boards, so colleagues and I have had one-to-one sessions with chief executives, directors of finance and others, and there has been detailed analysis.

[47] One of the big issues that has emerged from the review is the very significant increase in demand. That has come through, interestingly, from the beginning of the year and has been communicated, not from directors of finance, but from the medical directors. For example, the nursing directors have been saying that they are seeing more and more patients presenting into unscheduled care systems and more patients with higher degrees of dependency. So, our work was to verify and analyse that. We have done an enormous amount of analysis and, in my paper, I have shared some data that corroborate that particular assertion that the NHS is under increasing demand, particularly from the over-75 and the over-85 groups in the population. Wales has a greater number of those groups in the population, and we are seeing growth in ambulance transfers, accident and emergency attendances and admissions, longer lengths of stay, and more demand on the healthcare system.

[48] Health boards have responded in the right way; they have prioritised a clinical and high-quality response to that and have, therefore, taken decisions that have prioritised quality. We have assessed, quite rigorously, the financial impact of that growth in demand. We can do so by looking at the increase in demand and applying some notional real costs and benchmarking costs to the amount of additional cost that that demand represents to the NHS.

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Our assessment is that, in direct costs, it is in the order of £45 million this year, plus some indirect costs. So, we are seeing increasing demand, which has a direct consequence on the service's ability to deliver savings. We are seeing a reduction in the pace at which health boards, for example, are reducing the number of beds. This all triangulates in terms of what is happening this year.

[49] We are also seeing other pressures—there are pressures on our continuing healthcare—and while health boards have made significant reductions in spend on locum and agency staff, they are not quite at the level that we would anticipate. We suspect that, until some of the service changes are implemented, they will continue at this high level—

[50] **Jenny Rathbone:** Some health boards are making considerably more progress on that than others, while some health boards are going in the opposite direction. Betsi Cadwaladr University Local Health Board has increased its number of staff and the amount of people who are bank staff and agency staff, while others have met the target. So, how are you managing that? If your contingency fund is going to be used for those who fail to reach their targets, the ones who worked hard to make it will not be overly happy.

[51] **Mr Sissling:** The workforce picture is particularly complex. Generally, we are seeing slower reductions in the total number of staff employed than might have been expected. The Wales Audit Office report indicates some increase, but, since that time, it has reduced. However, the important thing is not just the numbers employed, but also the costs of employment. We are seeing very significant reductions in premium costs—in overtime, bank and agency costs. Our expectation is that, by the end of the year, the total numbers employed will be relatively static and there will be significant reductions in premium costs, so the spend on agency and locum staff—which was at £45 million, dropping down to £47 million, over the last two years—will reduce significantly, perhaps in the order of £10 million this year. That is NHS colleagues doing a very good job and, at times, taking decisions to employ more staff to reduce agency and locum costs.

[52] **Jenny Rathbone:** So, what are you going to do about the outliers that do not do that?

[53] **Mr Sissling:** We work with every health board. We are tracking this on a month-by-month basis. In our discussions with each health board, we are looking at their overall performance, and if it is such that we need to inquire about and pursue particular issues, we will take them up with them. We are also keen to make sure that best practice is shared; if one health board seems to have cracked a particular issue, we want to make sure that the knowledge and insight are available to other health boards. We are doing an enormous amount of work to disseminate good practice and to make sure that we are levelling up all the time. To an extent, it is about holding to account, but it is also about being supportive.

[54] **Jenny Rathbone:** The other big issue that comes out of your paper, which you mentioned earlier, is around the increase in the number of people over the age of 65 who are being seen—not just being seen, but being admitted. It raises the question as to how much your plans for breaking even financially are largely dependent on the ability of social services to care for elderly people who need some care in the community. The tendency is that, if social services are not rising to the challenge, people get pushed out to accident and emergency departments, even if that is not their wish.

9.30 a.m.

[55] **Mr Sissling:** I could not agree. Now is the time, probably more than any other time, when health, local authorities, NHS and social care need to work extraordinarily closely together. We will all be the losers if we allow any unhelpful tension or if we do not take advantage of the many opportunities that we know exist to work closely together, to plan

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together and, where it is appropriate, to pool resources and budgets, making sure that we look at the experience of the citizen, or patient, as a common journey rather than one that is separated by organisational divisions. We are seeing enormous benefits with those parts of the system that are becoming more accomplished at doing so. Our task now, working with local authorities, particularly through leadership arrangements, is to make sure that we accelerate that progress over the coming months and years.

[56] **Jenny Rathbone:** Obviously, the timescales involved are pretty scary, in that we have only another six months, and it is predicted to be the worst winter for 100 years. Is there anything that you think could—

[57] **Darren Millar:** We have some timescales this morning that we need to keep to as well, Jenny, if I could just remind you of them.

[58] **Jenny Rathbone:** Okay, I will let someone else come in.

[59] **Darren Millar:** You referred to your contingency budget, which you said is around 1%; what is that in monetary terms?

[60] **Mr Sissling:** I think that the Minister for Health and Social Services answered exactly the same question in another committee meeting—

[61] **Darren Millar:** So, the contingency is £50 million.

[62] **Mr Sissling:** It is £50 million, but we will explore options to develop it further, if necessary.

[63] **Darren Millar:** That was put aside on the basis that you did not think that the NHS would hit the year-end target. I thought that the impression you gave to the Health and Social Care Committee was that that cash was there to deliver concurrent services for health boards if they were planning to establish new ones as part of the service change programme.

[64] **Mr Sissling:** Yes; you have asked two questions. First, as I said earlier, with an endeavour as large as the NHS, which is a multi-billion-pound organisation, good financial management would involve an understanding of risk, and the development of a contingency of about the level of 1% would be very wise management. It would be interesting to hear the comments of the Wales Audit Office if we went into a year without contingency of any nature. I suspect that it might be quite critical of us. The application of that contingency is something to be determined by the Minister as the year unfolds. It is not quite as binary as either being directly related to the possibility of financial challenge or to do with transitional or pump-priming costs.

[65] The probability is that, at any point, it will be used in a way that offsets financial pressures, but the way that we offset financial pressures is to fast-track and support new ways of delivering care. Money does not just exist in its own boxed-in world. The NHS is not purely an economic model; it is a model that is predominantly about delivering clinical care. So, the response to some of the financial pressures is, for example, to focus on one of the ministerial priorities, which is the development of primary care. The response to this possible challenge of more elderly people presenting at the front door of our hospitals is to accelerate the development of care outside hospitals that can provide both better patient care and the better use of resources. So, they are not mutually exclusive. It may be that, in developing some of the ministerial priorities in terms of unscheduled care and primary care, we get into a win-win situation where we develop a benefit to the bottom line financially, but we also provide better care. Increasingly, we are getting more insight into the fact that the way to address the financial problems, paradoxically, is not through the director of finance's office,

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but through the medical director, the director of nursing and through the clinicians.

[66] **Darren Millar:** Forgive me, is that not the mixed message that the auditor general was talking about? On the one hand, you are saying 'There is no more money; you have to stick to your existing financial budgets. The envelopes are there and they are fixed', but on the other hand you are saying, 'We have £50 million in the bank ready to give you if you need it.' Is that not, essentially, the mixed message coming from the NHS? All of those finance directors are saying, 'We are trying our best, but we will still be £70 million short; at least there is £50 million in the bank to help us if we need it.' This is the difficulty, is it not? This is the paradox and the challenge that you face in trying to get your message across and that the NHS faces in trying to receive that message in health boards across the country.

[67] **Mr Sissling:** I understand the point, but, once again, I would say that the NHS, at a time of financial constraint with increasing demand, is in a position where there will be risk, which needs to be anticipated and managed. The huge centre of gravity of the responses in the health boards is that they are doing all kinds of different things to address this emerging position. They are restrengthening their plans, and we have seen an enormous acceleration. So, the idea that, somehow, the health boards and trusts are sitting waiting for central assistance is entirely wrong; they are doing an enormous amount as we speak.

[68] **Darren Millar:** I do not think that anyone is suggesting that. The worst case scenario that the auditor general points out is a shortfall of £131 million, which is well in excess of the £50 million that you have as a contingency fund. What is the consequence of the NHS not hitting a break-even position at the end of the year? In the event of insufficient reserves or contingencies being available to plug the gap—if the gap is of such a scale—what is the consequence for an individual LHB or for the Welsh Government in general? Does it mean that your accounts will be qualified, for example? Does it mean that these LHBs have you over a barrel, in that you have to bail them out at the end of each financial year? What does it mean if they do not hit their target?

[69] **Mr Sissling:** At a Welsh Government level, the decision would sit with the Wales Audit Office. It would take decisions on the particular circumstances that arose, and I could not or should not talk on its behalf. That will be a decision for that body, if those circumstances arose.

[70] **Darren Millar:** We will discuss that with it later.

[71] **Mr Sissling:** An important point of context is that health boards—I might ask Alan to talk about this, as someone who has worked for the Welsh Government and for health boards—are not in a frame of mind where there is any reliance on additional funding being provided. One interpretation seems to be that a health board might take its foot off the pedal because it knows that some support might be provided by Welsh Government. I would strongly contest that. Health boards are very clear about their responsibilities to deliver statutory targets. Their boards are in no doubt, from the very clear messages that the Minister has given to chairs and that I give to chief executives, that accountability means something, and that they have to deliver. We simply could not pursue and prosecute the arrangements that we have if there was any lack of clarity in that regard.

[72] Beyond that, in terms of what the specific consequences would be, it would depend on the specific circumstances that arose. We would be required to look at those and take commensurate action. Alan, do you want to talk a little about how it feels in terms of the service?

[73] **Darren Millar:** Can you also tell us what you would understand the consequences to be if your LHB did not break even?

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[74] **Mr Brace:** Just for clarity, my substantive day job is as the finance director of Aneurin Bevan Local Health Board. To go back to the first point, neither I nor my colleagues would understand that there are mixed messages. One of the benefits of an integrated system is that we fully understand the resources that are available for the health service in Wales. We also fully understand what is allocated to us by Welsh Government to live within our means. The ambition of boards is to put their services and finances on a sustainable footing. So, no-one enters the year with any assumption that, if we did not get there, something would happen at the year end.

[75] I guess, Chair, that that brings us to the question of the implications. From an audit point of view, we understand that, if we breach our revenue resource limit, it equates to irregular expenditure, which would result in a qualified audit opinion on our accounts. Everyone is absolutely clear that that is the environment in which we plan and deliver, and there is no confusion about that.

[76] **Darren Millar:** Your health board had some brokerage money last year. Would this £50 million be given in brokerage, or is it just a pressure valve relief for those health boards that might need it?

[77] **Mr Sissling:** The decision about that clearly sits with the Minister, in terms of the way that the contingency is applied. However, our analysis is very supportive of the view that the reason for this pressure is to do with demand. This is not about a sloppiness of approach—health boards have been incredibly rigorous—but they have experienced very significant demand. We have shared the graphs with you, and health boards have responded; we have seen a reduction in admissions for chronic conditions and bed days have come down, so the net impact is increased demand. In such circumstances, it would be inappropriate, in terms of the recommendation that I would make to the Minister, for this to be repayable money. This is not an end-of-year situation; this is a well-managed position, which includes risk, contingency, a mid-year review and a need for early decisive action to recognise increasing pressure. This is a different situation to the one that was described earlier.

[78] **Darren Millar:** So might those health boards that had brokerage last year, and which have been ruled out from brokerage this year, still be eligible for a one-off payment in order to meet those demand pressures?

[79] **Mr Sissling:** On the pressures, it is interesting to note that they are not in one or two health boards but are common; our analysis shows that they are in every health board. If it was just one or two health boards, you would say that there is something local there, but it seems to be across Wales. The graphs are incredibly consistent; we have validated them and looked at the evidence and there seems to be a general pressure across all health boards. The boards are seeing a very significant surge in demand, particularly associated with demographic change. The recognition of that should be made equally across all parts of the system.

[80] **Jocelyn Davies:** I wanted to ask about the contingency fund. Most people would think that you have a contingency plan in case something completely unforeseen happens, such as an outbreak of a disease like bird flu. However, you know that demographic changes are coming many years in advance. So, the criteria for this contingency plan are not necessarily for completely unforeseen circumstances.

[81] **Mr Sissling:** I will perhaps ask Kevin to contribute in response to that, but you are right that it is not a contingency fund with just one label on it. It would be a contingency fund for a number of possible risks. The overall principle is that should we not—this is a rhetorical question—with more than £5 million of spend, have some contingency to allow us to respond

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to unforeseen circumstances or developments in—

[82] **Jocelyn Davies:** They are not exclusively unforeseen circumstances; that is what I am saying.

[83] **Mr Flynn:** It would be easy to go on for a long time about the analysis, but one of the advantages this year in being able to look at the population is that we have preliminary data around the 2011 census. So, what you have in Wales is, basically, a 1% increase above the worst-case scenario from the 2008 projections related to population. That 1% is nearly all in over-85s—it is in the older age group. This is largely because of migration into Wales, from England predominantly; the migration into Wales was greater than what was anticipated in the projections in 2008. That has made a 1% difference in the population. The trouble is that the full projections from the 2011 census will not be available until next summer, and so we will need to do quite a bit of work around demographics to understand what that then means after that stage. There is a change, and it is above what was anticipated when the projections were done in 2008.

[84] **Darren Millar:** In terms of people with chronic conditions retiring to Wales, wanting to get out of the city and to the coast or wherever it might be, I assume there is a pattern to that drift. I presume that not all areas would have equal challenge in terms of the rising number of over-85s, would they?

[85] **Mr Flynn:** There are some areas, such as the north Wales coast, the whole border area and the south-west, which are particular hotspots. These are not just people who are retiring; the data show that this includes people over the age of 45, which means that a lifestyle choice is being made.

[86] **Julie Morgan:** How does this fit in with the evidence that we have been given in other reports that the birth rate is rising, particularly in Cardiff? We were told by clinicians that there was a 20% rise in the birth rate.

[87] **Mr Flynn:** Cardiff is the complete opposite of all the other boards. So, if you look at everywhere else, you see this inward migration of people over the age of 45 and, with Cardiff, it is the complete reverse. It is a very vibrant, relatively growing city, so what you have is young people coming into Cardiff and the older generation migrating out of Cardiff to other parts of Wales. However, it is very early days with the data unfortunately, because we will not get the projections until the summer.

[88] **Aled Roberts:** On the issue of workforce costs—

9.45 a.m.

[89] **Darren Millar:** I think that we will come to questions on the workforce a little later on, if that is okay.

[90] **Aled Roberts:** Okay, I will come in then.

[91] **Darren Millar:** We will now move to financial forecasting.

[92] **Gwyn R. Price:** The auditor general's July report refers to inconsistencies in the information that the health boards provide, with some providing the Welsh Government with optimistic forecasts. Are you confident that health boards are improving their financial forecasting, and can you assure us that the most likely end-of-year forecasts reported in the auditor general's update paper are robust?

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[93] **Mr Sissling:** I will start and I will ask Alan, who has been working with the director of finance, to develop the response. The critical issue is that analysis of the most likely outturn from health boards, which was played back by Wales Audit Office as the one that we should work to and which was based on a very thorough review—not just a desktop review, but an eyeball-to-eyeball review of the position—said that it was the right basis on which we should plan for the rest of the year. So, the answer to that is that we believe that it is the basis on which we should plan. We should, of course, understand the extremes. There was a best and a worst case, so there is a range, but, at some point, we have to fix on a figure, we have to act on that figure and that becomes the basis of the movement to the end of the year. Alan, do you want to talk about the forecasting and the analytical issue?

[94] **Mr Brace:** I would have to recognise that, early on, as health boards were forming and starting to put plans together, there were issues around the quality of the forecasting. It looked quite variable across Wales. I think that that has improved significantly now, so I am less worried about the quality of the forecasting. The next big development agenda that we have been working on this year is profiling across the year. There is still the issue of some of the profiles across the 12 months needing further work, to make sure that we pick up on some of the points that the auditor general raised and to make sure that we sit financial opportunity and financial risk more closely together in an even pattern across the year—not what we have seen, which is the building up of big deficits and the turnaround late in the year. So, forecasting has improved significantly and profiling is the next area for development over the 12 months. I sit down every month with the finance directors and the Welsh Government finance team and we look at the in-month performance, the profile for the year ahead and the forecast. So, this is continuously work in progress in terms of how we improve our profiling and our forecasting.

[95] **Gwyn R. Price:** Does the fact that the most likely deficit forecasts produced by four health boards are the same as their best-case forecasts suggest that they may be overoptimistic? What support has the Welsh Government provided to help NHS bodies to improve their forecasting?

[96] **Mr Brace:** At the six-month stage, you would hope that the ambition of all the boards is to plan and aim for the best case. I will take my own health board as an example; our best case is break even, and our most likely is break even. The ambition of the board is to make sure that we live within our means by the year end. So, those two numbers are exactly the same.

[97] **Gwyn R. Price:** [*Inaudible.*]

[98] **Mr Brace:** This is about managing risk. All of our plans are predicated on making sure that we achieve the requirement for the board to break even. At this stage there is risk to manage, but those plans are being progressed and those risks are being managed.

[99] **Mike Hedges:** I spent six years as a non-executive director of Swansea NHS Trust between 1998 and 2004. On profiling, it was a case of substantial overspend in the first quarter, overspend in the second quarter and then pulling it back to a minor overspend by the end of the fourth quarter. Everything you have said, and everything I have seen, seems to say that we have not moved on much from there, in that we still have that situation of huge expenditure in the first quarter, followed by panic and trying to get it back over the next three quarters. Then, in the last quarter, we do anything to try to get as close as we can to breaking even. Surely there must be a better way of financially managing an organisation.

[100] **Mr Sissling:** To kick things off, I would agree with the analysis. It is improving. We are being very insistent on a different approach to the profiling and management of expenditure through the year. We need to know what the position of the health board is as

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accurately in the first, second and third months as we do in the ninth, tenth and eleventh months. A lot of this is to do with profiling, as Alan has mentioned. So, there are improvements, we are insisting on changes, and we are intervening where there are clear examples of inappropriate or unacceptable practice.

[101] A further issue raised by your question is whether we should be looking at a planning time period of beyond a year. Should we be looking at two or three years, accepting that year one will be very firm and clear, and that things may be slightly less clear by the end of year three because some of the planning assumptions are less certain? That is the direction of travel, and it will be extraordinarily helpful in effecting a real change in the way that we have a financial regime that is cognisant of and sensitive to some pressures and changes.

[102] **Mike Hedges:** I would be looking for you to have a profile of 12 quarters rather than a profile of three years. You have a better understanding of what is happening in quarters. If, at the beginning of each year, you have a problem in the first quarter, you are always going to be playing catch-up for the rest of the year.

[103] **Aled Roberts:** I would like to pursue that point. If we moved to a three-year period, given the history that Mike has provided dating back to 1998, what confidence would we have that we would not then have even bigger panics in the last six months of the three-year period than we would have in the tenth and twelfth months of the one-year period?

[104] **Mr Sissling:** That is a very valid question. It appears attractive to have a three-year period. However, the danger is that you can backload all of the problems; rather than coming in the fourth quarter of year one, they would come in the last half of year three. So, this would have to be associated with a significantly more rigorous arrangement to ensure that there is the same delivery in the first of the 12 quarters as there is in the last of the 12 quarters. We do not want to just replicate the position over a longer period. So, this would be predicated on much more rigorous planning and accountability arrangements. However, it would at least allow us to recognise that not everything can be contained and constrained within a 12-month period. Some elements of managing and planning something as complex as the NHS should be done over a longer period. This would not be to say that the point of judgment is at the end of year three. There would be important judgments about performance at the end of year one. It would have to be on target and in line with an approved plan. So, there would be no licence to put it all under the heading, 'bring forward to year three'. It would have to be a much stronger system.

[105] **Aled Roberts:** I wish to look at the rigour in the current system. Apart from one month, which itself was borderline, the targets have not been met in any of the first six months as far as savings are concerned. It is worrying that, in looking at the figures, we have a lot of backloading as far as the second six months of the year are concerned; we have demographic concerns, in terms of a more elderly population; and we have the winter. How realistic is the current profiling, and how have you accepted this as a rigorous statement of fact? If we look at the level of savings required in the second half of this year, they are much greater than the level of savings achieved in the second half of last year, when there were staff recruitment freezes and deferrals of equipment purchases. In reality, those were one-off savings, and if we rely on the same situation this year, there is likely to be a great public outcry.

[106] **Mr Sissling:** I will first address how we assure ourselves—that is, the Welsh Government—about financial status prospects. We do not rely only on the data, analysis and graphs. They are really important, but there are also a number of interactions, such as those between financial colleagues: the director of finance at the Welsh Government level and the directors of finance at each organisation. There are one-to-one meetings with each of the health boards, which I lead on a regular basis. We have had specific in-depth meetings and

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deep-dive discussions over the last few weeks and previously, at the end of the first quarter. The Minister has met up with the chairs to impress upon them the need for absolute focus on performance. It is ramped up a level from where it was previously as regards accountability and interaction arrangements, because we cannot just rely on the document. That is the first thing to say. We are now a lot more certain about the position that is being conveyed to us.

[107] We have also improved financial forecasting. At six months, we are now saying to health boards that their plans have to be absolutely clear. They should not be aspirational or in any sense vague at the margins. They need to be absolutely clear and we have been through that with all of them. To an extent, they have a responsibility to their boards, to ensure that their plans are deliverable and allow confidence in the trajectory of improvement in savings for the rest of the year. We have upped the ante in terms of the extent to which we are performance managing and the health boards are performance managing themselves. We are also clear about the consequences in relation to the issues that you alluded to, as regards whether there will be reductions in service quality in the coming months. We have been through these issues and have explained that it is really important that we maintain a pattern of improving services over the coming months to ensure that there is not a trade-off between service quality and delivery and financial measures.

[108] **Mike Hedges:** The key question is: how do you stop fourth-quarter savings in one year from being first-quarter pressures on the subsequent year?

[109] **Mr Sissling:** There is a bit of mythology about the fourth quarter, the last month or month 12 that the facts contest.

[110] **Mr Brace:** The point is that we have to start looking at this over the medium term. You are right that it is better to describe 36 months than the current accounting system, which is measuring things from 1 April to 31 March. There is no truth in the suggestion that we do something mysterious by holding back spends in March and that they then bubble up in April. One of the issues that we have to tackle is that our expenditure has been quite consistent over the year end and the first quarter. That has been part of the problem of getting the tractions in-year on some of the savings.

[111] To use a practical example—this is where it is sometimes better to take a broader look than 12 months—one of the things that we have managed to achieve through our shared services is that we have engaged with all the orthopaedic surgeons in Wales to have an all-Wales contract for orthopaedic implants. The first six months of this year were spent working on getting the clinical consensus and procurement in place. We will see some benefits from that at the back end of this year in terms of savings, but we will see significant savings going forward, and it gives us the confidence to start tackling some of these clinical procurement issues on an all-Wales basis. If you look at in-year, it will look like we are making a lot of savings in the last quarter, but if you extended the time frame, you would see that this is going to give us a good recurrent platform and basis in terms of maximising some of the benefits that we now have from being an integrated system with people working together.

[112] **Jenny Rathbone:** Despite all good intentions and the improved consultations that you have had with the health boards, you still have two health boards with best-case-scenario outturn deficits of £19 million and £20 million. I do not understand how these discussions are tackling that. You all seem to be moving towards the same understanding that you will have these massive deficits. The question is: what is going to happen then? Are you just going to refuse to bail them out, given that you have already had all the discussions about what they should have been doing, or are you simply going to let them off the hook again?

[113] **Mr Sissling:** I do not think that it is a question of bailing out or letting off the hook. We are looking at the position at an individual health board level, looking at the

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circumstances of the health board and the pressures that it has experienced in terms of demand. As I have explained previously, we see this pressure and this is the cause of it. We are also looking at the relative performance of health boards and it is a reasonable question that goes back to the issue of equity and fairness, that is, whether it is reasonable that there is a common or differential response to different health boards in terms of the circumstances that arise in individual health boards. The approach that we are adopting will be one that takes account of those issues, and the specifics of that will be announced by the Minister next week.

10.00 a.m.

[114] **Julie Morgan:** I want to ask about workforce reductions and savings. You have covered some of this already in your responses to Jenny Rathbone, in particular. Why are health boards struggling to deliver the intended workforce reductions and savings in the short term? You have told us about the increased pressures. Is there anything else that you could say to account for the struggle that there is to reduce the workforce?

[115] **Mr Sissling:** First, I think that it is an entirely responsible position to adopt if there is more pressure to make sure that the staff, doctors, nurses and others are in post to respond to the pressure. To do otherwise would be very worrying. So, the fact that health boards have put safety and meeting patient demand appropriately first is the right decision and we entirely support that. To bring the committee up to date, there is an interesting analysis. We have updated it as we have had October's data, whereas the information that was provided by the Wales Audit Office was based on September's data. Due to the movement in October, there was an overall reduction for the period involved of some 76 contracted staff—the number of people who were on the payroll. However, the equivalent reduction over the period in terms of paid staff, which is where the costs are, was 490, which shows that we are bearing down on premium costs. Health boards are managing pay costs. In some cases, employing more staff would allow that to happen, because it avoids the need for expensive bank agency overtime.

[116] So, we are behind—if that is the right word; perhaps it is not a term I should use in terms of the numbers employed—but are actually managing all double-time and time-and-a-half costs, the expensive agencies, and the calls to bring somebody in at six hours' notice to cover a shift, which is where the money really leaks out. So, I think that we are beginning to see some very careful, good management of workforce, which is one of the keys to the future. We know that 70% plus of our expenditure is on workforce—predominantly clinical—and it goes straight back to the issue that the real solution to many of our challenges is to think and work through clinical solutions, rather than simply accepting that an arbitrary reduction in the number of staff is the answer, because that does not equate to the demand. The answer is that we are behind some demand, but we are much more in-line with where we want to be in terms of the overall costs, which is what bears down to the bottom line.

[117] **Julie Morgan:** And what about the longer term planning?

[118] **Mr Sissling:** The longer term planning is increasingly looking at a three-year period; whatever the financial regime, our plans can cover and embrace a three-year period. It is fair to say that there is still more work to do to bring the various elements of the plans that we need to see on an integrated basis—the revenue, capital, clinical service change and workforce—into a common integrated plan. I think that that is work in progress; I would be wrong to say that it was completely done, but it is work in urgent progress and we recognise that that is something that we need to do make sure that we have the right assumptions and the right knowledge of three years' time—broadly, which staff will be required to provide the right services. That also feeds into areas such as the commissioning of education and work with the universities and colleges that provide the pipeline of talent for the future.

[119] **Julie Morgan:** Do you think that the reduction of 2% impacts on service quality and

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patient care?

[120] **Mr Sissling:** Not if we get it right and we look to introduce the right flexibilities, teamwork and multidisciplinary working. I think that we need to challenge some of the traditional ways of working and we need a workforce that is much more dynamic and fluid. As mentioned earlier, we need to work much better between health and social services. We need to see a common workforce and a common endeavour, and we need to work better with the third and voluntary sectors to ensure that that contributes to some of the challenges in the future. We are very conscious of the impact of workforce reductions, and while we would not be driven by arbitrary percentages, we would be looking at any point to make sure that we have plans to bring the best out of the workforce in every sense.

[121] **Darren Millar:** Before you move on, Julie, Aled has a question on this. Will you keep it brief because we are up against the clock?

[122] **Aled Roberts:** I have two brief questions. First, on management costs and pay protection, what is the cost of the recurring packages that were offered within these figures? Secondly, how do guarantees given with regard to increasing staffing ratios—such as in neonatal care in north Wales, for example, where the Children and Young People Committee discovered a huge degree of under-recruitment to specialisms, including nurses and doctors—factor in when reconfiguration plans give an assurance that the health board will meet national standards, which would lead to a significant increase in staffing?

[123] **Mr Sissling:** There are three parts to that. First, I believe that the overall reduction in management costs is in the order of £32 million, which we have achieved over the past couple of years.

[124] **Aled Roberts:** What about the cost of pay protection?

[125] **Mr Sissling:** I do not have that figure. I am very happy to provide it subsequently, but I just do not have it to hand. I understand that you have raised the question, and I am very happy to come back to you with those particular details, on what the figure is and the scale by which it is reducing for all the very good reasons.

[126] It is important to say that the costs associated with the kinds of things that you described are the areas where we need to develop staffing levels to allow us to meet quality standards and they are part of the reason why we have these savings figures of 5% rather than 3%. At the beginning of the year, a health board will examine what it needs to do in terms of some of the inflationary pressures, but it will also produce a complete list of those areas that are driven by service needs—they might be things to do with the introduction of new drugs that have been recommended by NICE, or increases in staffing levels where standards say that that is required. So, when we talk about these big figures—the £250 million and £300 million—they are not just cutting costs; they are recycling money into the service, at times to enable very necessary developments in areas that are under pressure. So, the health boards—just as they should be and as we would want them to be—are driven by quality issues and, at times, they calibrate the levels of savings to ensure that they can deliver the highest quality services, or those that are in line with the standards, such as the neonatal services. So, somewhere within Betsi Cadwaladr LHB's reconciliation of this, the requirement to invest in neonatal services will feed into its overall financial plan. It is not a separate issue, and that is the reason it has to deliver such big savings for parts of it.

[127] **Darren Millar:** Briefly, Mr Brace, yours is the only health board that has actually exceeded its staff reduction target. Is that to do with shifting services out of Neath Port Talbot Hospital? How have you managed that?

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[128] **Mr Brace:** That is not my health board. I am with the Aneurin Bevan Local Health Board.

[129] **Darren Millar:** Pardon me. In that case, do we know how Abertawe LHB has managed to achieve that reduction in staff? Is it as a result of services being lopped?

[130] **Mr Sissling:** All the staff from Neath Port Talbot Hospital transferred to other locations.

[131] **Darren Millar:** What is the rationale? How has it managed to achieve such an enormous reduction in staff? It is 206 against a target of 120, while every other health board, with the exception of Cwm Taf, has gone in the opposite direction.

[132] **Mr Sissling:** I could not tell you, but it may be something on which we could provide more detail in terms of how it has delivered those savings.

[133] **Darren Millar:** That would be helpful. It would be interesting just to see how it has done it and whether it can be replicated elsewhere; that is all. Of the others, the one that is wildly out is Betsi Cadwaladr LHB, and we shall be speaking to its representatives during the course of our inquiry. Let us come back to you, Julie.

[134] **Julie Morgan:** I have a final question. What are the main areas where the health boards have struggled to maintain performance in the first half of the year?

[135] **Mr Sissling:** I suppose that it would link very much with the earlier commentary that the pressures on unscheduled care and on ambulance transit times have been significant. We have just about managed to sustain performance at the previous level, but that has required an awful lot of innovation and real-time work by health boards. To an extent, the pressure on the unscheduled care system at times also plays into planned care and elective care, because it can have an impact on capacity. So, there have been some pressures there, but we are in a much better position in, say, orthopaedics, than we were at this point last year. At this point last year, I think that we had over 5,000 long waiters, that is, the 36-week-waiters. At the moment, it is about 700 or 800, which is not where we want the figure to be, but that puts it in context. We are in a better position this year, because we are desperate to hang on to the improvements and to reduce the figures for all those long waiters.

[136] **Mike Hedges:** On the transformation agenda, looking forward to 2014-15, what are the key areas of transformation for the NHS in Wales, and how are you ensuring that health boards' plans are financially sustainable?

[137] **Mr Sissling:** I will kick off on that, again. I suppose that the main area of transformation will be prevention. We need to get much better at focusing on prevention. We have always been very clear that that is an issue, and now we want to up our game. The Minister is clear that we want to make sure that we support the parts of Wales that have the greatest health challenge, where health inequalities exist. So, there is a big focus on prevention. Also, there is a big focus on developments in primary care, and the Minister has also championed that, making sure that we develop primary care, and that we have the right networks of professionals working together in health and with social services to enable preventative, anticipatory care and integrated care within the health service, between secondary and primary care, and between health and local authorities. As we know, we need to make sure that we can appropriately reshape aspects of hospital service delivery to make them sustainable and resilient for the future.

[138] **Mike Hedges:** On preventative care, I was in a school yesterday and saw a presentation on teeth cleaning, and some children clean their teeth twice a day at school. That

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is highly preventative, but the benefit will not be seen next year, but 10, 15 or 20 years down the line, or even 40 or 50 years. You have actions that are taking place today that will benefit people a long time in the future. So, there are costs today and benefits tomorrow. I think that it is an excellent idea, but you have the problem that the costs are falling to be paid now.

[139] **Mr Sissling:** That is right, but we would still argue for and advocate investment in the health of the population. Some of it is almost generational, and some of it can be very much more immediate. We are seeing reductions in the levels of teenage pregnancies in Wales, for example, which has happened quite rapidly through very focused investment and by attention being given to some problematic issues. So, some of the benefits will be 10 or 20 years away, but some preventative work can have immediate benefits, particularly if we get primary care right, because some of it is about risk detection in the population and an ability to mobilise the right responses today or tomorrow, rather than in years to come.

[140] **Mike Hedges:** I preface my next remark by saying that I really support preventative work and think that it is really important. However, if you are very successful in your preventative work, your overall number of over-85s and over-90s will increase.

[141] **Mr Sissling:** Yes, that is true.

[142] **Darren Millar:** You are ever the optimist, Mike. [*Laughter.*]

[143] **Mike Hedges:** No, but it is a fact. We want preventative work to work, and we want everybody to live a long time, including ourselves, but—

[144] **Mr Sissling:** I would hate to give the impression that we see the more elderly as a burden. It is a group of the population that we should celebrate, and which has a rich contribution to make. The preventative work in every sense has enormous benefit for the population. So, the net benefit is clearly demonstrable.

[145] **Darren Millar:** We still have a few questions left that we want to ask, and I am conscious of the time, so we will shift on to gain a few more minutes. Jenny will come in in a second and then Oscar. However, I want to ask one thing first.

[146] One part of your paper refers to capital investment. Obviously, there has been a significant reduction in the capital available to the Welsh NHS for investment in the new services and buildings et cetera that might be required as a result of service reorganisation. You have hinted that you are looking at other options for capital investment, with the very low cost of borrowing et cetera, and that perhaps third parties could come in to develop that. Can you tell us a little bit more about that? Will this be in the paper next week, on which the Minister will report back to the Assembly?

[147] **Mr Sissling:** Not specifically, from my understanding of the announcement that she will be making next week. However, some work is being led across the Welsh Government on the different options for securing capital.

10.15 a.m.

[148] **Mr Brace:** It is a real issue for us. I think that we have a really good track record with the development of the all-Wales capital programme, but we recognise that the future will require a different approach, so we are working with colleagues in central finance as part of the Welsh infrastructure investment plan. However, we are also looking specifically at what that could mean for us in health, and that work is ongoing at the moment. We hope to see a different approach emerging to how we work centrally and what that means for us in health.

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[149] **Darren Millar:** It is one of those obvious areas where there could be a weakness in plans going forward unless the capital is available to invest upfront. Jenny, would you like to come in at this point?

[150] **Jenny Rathbone:** Yes. Given the rise in the expectations of clinical standards and the financial constraints, 'no change' is not an option. How well do you think NHS bodies are addressing the problems that have hampered NHS reform in the past, taking clinicians, the public and the associated lobby groups with them on the necessary changes?

[151] **Mr Sissling:** It is difficult stuff, but I think that the NHS is getting much better at this. I must say that I am particularly impressed by some of the work that the south Wales health boards have done, first in approaching it on a south-Wales basis rather than having a number of separate interactions, but also in the attention that they pay to securing—as best they can in the circumstances, given that there will be a huge diversity of views from clinicians—a degree of clinical consensus on the need for change and the options for change. They were very attentive and invested their time wisely. They also developed that into conversations with external stakeholders, the public and elected representatives.

[152] My assessment is that there is a path of improvement but that there are still things that we can get better at. There are still times when we get it wrong, and I think that we should be open about that and not become defensive about it. However, with regard to the scale of the changes ahead of us, this is a continuous challenge. In a sense, we should see it as a positive opportunity to interact with clinicians. In the end, they have the knowledge about the best way that care can be delivered, along with the public, who are the users of the service and who have an enormous, enthusiastic interest in how we can improve it, and stakeholders, who are very keen to engage with us. So, I think that we need to ensure that we are receptive to views and not see this as a narrow managerial endeavour. I think that we are making progress and becoming much more open and receptive to different views and influences.

[153] **Jenny Rathbone:** Okay, so that is qualified optimism. Obviously, in south Wales, we have done the easy bit, to some extent, which is mapping where we need to go. However, we have not yet announced that we are going to move X service to Y place. Let us wait and see. How far do you expect the health boards to go in publishing detailed analyses underpinning their plans for reconfiguration, including the financial risks and benefits and, most importantly, the performance risks and benefits?

[154] **Mr Sissling:** I suppose that I would have to say that they should go as far as they possibly can, stopping short of breaching confidentiality. The Minister has made it absolutely clear that she wants to see more open and transparent arrangements, and surely that should apply to the process of service change. The plans that describe the underlying issues and the consequences and implications should be published, I think, and made available appropriately to all those who have an interest in them. I cannot see any argument for being cautiously guarded about that. I think that we should be very open. I see that as an asset rather than anything else.

[155] **Jenny Rathbone:** On the need for really quite substantive change, what evidence is there of tensions between the NHS and local government over costs and savings and the impact on their relationship?

[156] **Mr Sissling:** Just to tilt the question another way, I think that there is an awful lot of evidence of the benefits of working together. I hear all this 'traffic' about cost shunting or shifting, or whatever the term is, but it all seems to be generalised and somewhere over there. It is very rare that I become aware of specific issues with tensions that are detrimental to service provision. It is quite the opposite. Increasingly, I see health boards and local

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authorities recognising the common benefit of working together. Some of our superb set-piece examples of development, whether the Gwent frailty project or the things happening in Anglesey, show remarkably what happens if we work together. I am aware of the general noise about it, but I am perhaps more aware, heartened and reassured by the ability of the different parts of the public sector to work enthusiastically together.

[157] **Jenny Rathbone:** Lastly, what is the Welsh Government doing to foster political support for clearly argued change?

[158] **Mr Sissling:** To an extent, that is done, again, through engagement, being open, receptive and available to explain the reasons, by making sure that local parts of the NHS are working with politicians locally so that there are good conversations and discussions about local services, with us complementing that, where appropriate, to make sure that there is national-level description. So, one thing that I know the Minister is keen to do at some point over the coming weeks and months is bring together the national picture of the service change to make sure that it is one coherent, aligned whole. That would be a part of that, to make sure that we can set out the all-Wales picture of service change, and so that when you put what is happening in the Cardiff, Hywel Dda and Betsi health boards together, they actually align and are mutually supportive.

[159] **Darren Millar:** We will soon have to close with the final question, but before we do, I have a question. The national clinical forum has been a bit of a headache for the Minister of late, as a result of the actions of the chair of that forum. You are the custodian of the process of reform, I suppose, at the top of the NHS in Wales, to make sure that the processes are robust. Do you have anything to say about the possibility of what we have seen with the NCF undermining service change and the confidence of the public in the service change process? I can see Mr Flynn shaking his head, but I would like to hear from you on that, Mr Sissling. It clearly hit public confidence in the belly, I have to say.

[160] **Mr Sissling:** I would not comment on that, but I will comment on the question that you asked. The national clinical forum was set up to support health boards and to provide authoritative impartial advice. It works closely with health boards, as it should, and has done so in a way that is helpful to taking the process forward. It is a body that will continue to support the health boards. I think that, ultimately, the test is the quality of the plans. We get involved in a lot of stuff about this and that, but ultimately the test of all this is the quality of the plans and, over time, the response and the reaction of the public to the plans. Were we able to demonstrate that they offered an improvement? Are we able to demonstrate that the plans for the NHS in Wales will take us in a positive direction, not just over the next three months but over the next three to five years?

[161] **Darren Millar:** Specifically on the interaction between the chair and the chief executive of the north Wales health board and the report that was changed, do you not accept that it undermines public confidence when such things emerge?

[162] **Mr Sissling:** No, I do not, actually. The members of the national clinical forum—

[163] **Darren Millar:** I am talking about the chair now.

[164] **Mr Sissling:** Yes, and I am responding about the members. The members of the national clinical forum are absolutely clear about this. It is a group of very senior clinicians, and I think that we should be sensitive to that. These are clinicians who have authority in their own areas and who have a position of status. That means that when they say that views are put together by the national clinical forum, they are the views of all the membership, and not of the chair or the health board. It was the views of an authoritative group of clinicians that determined the final product of the forum's working. It was the forum that made the decisions

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about the advice that it offered to health boards, and it was all members of the forum who were involved in that. All members of the forum have gone on record as saying that it was they who said that.

[165] **Darren Millar:** It was a significantly different overall view from the original draft, of course. Oscar is next.

[166] **Mohammad Asghar:** I think that you have explained my question on a certain level, but the fact is that I am going to ask you a totally different question. During the third Assembly, one of your colleagues said that 20% of the national health budget is being spent inappropriately. Perhaps 20% is too high—10% might be the right figure—but it is still in millions. Have you learned any lessons? We have not seen any forecast, or anything, of how the budget at that time was prepared and presented to us, in exactly the same way. I have not seen those comparative figures, to ensure that you have learned some lessons, and have put adjustments in the figures, and, as you said earlier, dealt with the challenges. Therefore, regarding all these challenges, how will you tackle your forecast in this term?

[167] **Mr Sissling:** I am not sure that I would agree with the 20% spent inappropriately.

[168] **Mohammad Asghar:** It was mentioned.

[169] **Mr Sissling:** That is my personal view. I would not confirm that as the basis on which we should look at the NHS; that is not a view that I would support. Each year, and each subsequent year, we have to look at the challenges, and we have to take action to live within our means. We need to be careful about using words such as 'transformation'; a lot of this is to do with the good management of money—it is good housekeeping, and good attention to efficiency measures, involving clinicians who know best how the money is spent within their particular areas of expertise. It is about looking at issues such as good procurement and the return on money—the kind of things that Alan spoke about. Why should we use a multiplicity of different devices and replacement hips or knees for orthopaedics? Can we not make it more consistent, and ensure that we drive some funding out of the system? Doing something like that seems to me to be an entirely appropriate way to explore and pursue this efficiency issue. Those seem to be the examples that we should pursue. Looking at continuing healthcare is one example, where we have been able to bring care closer to the point of residence, and have saved enormous amounts of money. At times, we were spending huge amounts of money in private facilities or NHS facilities in England. However, if we can spend some money, and invest some money, we can bring the care of that individual much closer to home, and that is the kind of thing that we are getting better at. Therefore, the approach is changing. This is not an accountancy-driven approach; it is a more general endeavour, which is predominantly based on an understanding of the importance of good patient care.

[170] **Darren Millar:** Thank you. I am afraid that the clock has beaten us. We are very grateful for your attendance this morning, David Sissling, Alan Brace and Kevin Flynn. We are going to have to move on. However, I believe that you have one final question, Jenny; please be very brief.

[171] **Jenny Rathbone:** Do you have more information about this significant increase in over-65s coming to A&E departments? It would be useful to see where someone has broken their hip and has to go to hospital, or where people are being dumped in A&E because social services are not there.

[172] **Darren Millar:** The clerks will drop you a note in terms of the additional information that was also promised. We are very grateful to you. Thank you.

10.29 a.m.

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Cyllid Iechyd—Tystiolaeth gan Gonffederasiwn y GIG
Health Finances—Evidence from the NHS Confederation

[173] **Darren Millar:** We are joined for this item by Helen Birtwhistle, the Director of the Welsh NHS Confederation. Hello, Helen, and welcome to committee; we are delighted that you are able to join us. We will go straight into questions, if that is all right. We apologise for having kept you waiting a little.

[174] **Ms Birtwhistle:** That is all right.

[175] **Darren Millar:** I am afraid that we are up against the clock this morning, but we are very grateful for your coming in again to talk about NHS finances. I am sure that you have spoken to many committees about this issue in recent months. I will start the questioning, if that is all right. If you want to make a few opening remarks, in your response to me, that is fine.

[176] It has obviously been a tough year—everyone accepts that, in terms of where the NHS is. However, this committee is looking at future, as well as current, financial years. Do you believe that the situation ahead is looking more challenging than it was when you came before the committee last February, or are you more confident that the NHS will deliver, given this difficult financial backdrop?

10.30 a.m.

[177] **Ms Birtwhistle:** There is no doubt that the situation is extremely challenging. Things have changed since I was here last in February. The NHS has worked extremely hard to deliver enormous savings and performance changes and increases. It is still doing that and it knows what it has to do. I know that I have said that before, but it is absolutely the case. The money is the money, and the NHS knows what that money is and it has to work within it to break even.

[178] The NHS this year has to deliver £317 million of efficiency savings in order to break even, and the auditor general has predicted, from health service figures—it is from our figures, so we accept it—an estimated deficit of £70 million on the NHS saving plans this year. Yet, to put that into the wider context, the NHS is still on course to make £220 million of savings this financial year, at a time, as you have just heard from David Sissling and colleagues, of unprecedented demand—on top of savings of £285 million plus in the last financial year—by reducing and containing costs, reducing capacity and redesigning services. I want to put it in context that the NHS is doing a good job under very difficult circumstances. We must remember—I am sure that you all have contact with your various health boards and constituents—what the NHS is doing well, and not just, as we see from the figures, what it could do more, as it undoubtedly could.

[179] **Darren Millar:** The Welsh Government really appreciates the scale of the challenge for individual health boards across Wales. Is it doing enough to help and support them, or is there a sense among health boards that it does not understand the pain and difficulty that they are going through and that they need support to deliver what they are expected to deliver?

[180] **Ms Birtwhistle:** I think that the health boards feel supported; they feel challenged and they know what their responsibilities are, which is tough—there is no question about that. Everyone is under pressure. I heard part of the session that has just taken place and we welcome, for instance, the indication that there is going to be a contingency, which seems to us to be sound financial management. I have a contingency in case my roof blows off—I hope that it does not, but if it does, I can pay for it. I understand that the mid-year review that the

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Minister has asked for will be published next week, and it will be interesting to see the results and how that plays into what health boards are doing.

[181] The health boards are working hard and the Government is working hard. We must work together. The health boards work closely with Government. It is clear from the figures that we have in front of us today, which are our figures, and from the evidence that has just been given, that everyone understands that this is not a walk in the park.

[182] **Gwyn R. Price:** What are the main causes behind NHS bodies' £69 million deficit and how much confidence do you have that NHS bodies will deliver their forecasts of containing the deficit to £70 million at the end of the year?

[183] **Ms Birtwhistle:** Again, it is very tough and the figures are NHS figures. What they demonstrate is that, despite savings, despite changing services and despite containing costs in many areas, the demands on the health service are rising. The question was asked earlier 'We know that there are demographic changes, can we not expect some of these?' Yes, we can expect them and we can plan for some of them, but they have risen beyond our projections and we have to find ways of dealing with that. So, there will clearly be an increasing challenge to contain the cost within the current level and there may need to be more support to do that. However, the health boards are aware that there are certain plans in place and they are working through those. Some things do not come to fruition, as we have heard, until the third and fourth quarter of the year.

[184] Another issue that has been touched upon, certainly by this committee, is the issue around year-on-year financial flexibility. The last time that I came to the committee, I said—I will say it again, because I quite liked it—that it is like landing a jumbo jet on a postage stamp to expect the health boards to come in on budget at midnight on 31 March every year. You responded positively to that, and we understand and know that the Government is working closely with health boards to introduce some of that financial flexibility over, possibly, three years. That does not remove the accountability, but it gives a bit more leeway and more scope for better and improved planning. Those are the circumstances and the environment in which they have to work.

[185] **Gwyn R. Price:** I do not get much confidence that you will come in under £70 million, because something may take you over that £70 million; that confidence does not come over. Is it true that some parts of the NHS in Wales think 'The Government will have to help us out anyway, so we will try our best, but, at the end of the day, it will have to meet the budgets'?

[186] **Ms Birtwhistle:** No, that is absolutely not the case. My job is to represent members of the confederation, which are the seven health boards and the three trusts. I always feel strongly—I do not want to get defensive on their behalf, because they can stick up for themselves—that we take a pop at managers and their competencies; I am not suggesting that you are doing that now. However, they are highly effective and dedicated people who know what their responsibilities are. They understand their responsibilities and are working their socks off, in conjunction with staff, executive directors and partner organisations such as social services, to deliver not just a service within a financial envelope, but a better and higher-quality service. We are seeing things changing and improving all the time. I think that we tend to forget that when we look at the bald figures that we are dealing with.

[187] **Darren Millar:** I have a question on the demographic challenge. The health board with the biggest projected overspend is Cardiff and Vale, and we heard from Mr Sissling that its demographics are going in the opposite direction to the rest of the country—the average age is coming down. So, why would it have the worst nightmare scenario with its finances when some of the others, with older demographics that follow the national trend, have less of

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a problem?

[188] **Ms Birtwhistle:** There may be other things at play. I know about the rising birth rate and other issues. Cardiff and Vale and Betsi Cadwaladr LHB will be coming to talk to you next week, and they will have the— I am not party to the detailed financial or demographic figures.

[189] **Aled Roberts:** You referred to the financial envelope. Regarding the profiling of savings, could you explain the logic behind back-loading savings to the second part of the year? Most of us would think that there were greater challenges in the second half of the year, because of the winter months et cetera, particularly with an older demographic. Can you also explain why we would have confidence in the health boards' ability to deliver on their targeted savings when, in five of the first six months of the year, they failed the target and delivered £68 million of collective savings against a target of £105 million?

[190] **Ms Birtwhistle:** On the first question, about back-loading, my understanding—I am not a financial expert; you will have the opportunity to put questions on the financial detail to others, as my role is to give you the overall picture and to tell you what it feels like on the ground in the health boards—with some of the longer-term changes that are being made, is that it will take a while for the savings to come through. To give you an example, Cwm Taf Local Health Board has introduced a new at-home service for assessment and intervention. That will apply to all age groups, but it is particularly pertinent for older people. That will deliver savings, but it will take time; those savings are not anticipated until the back end of this year or possibly even 2013-14. So, a lot of things that happen in the health service cannot happen overnight; they are longer term savings.

[191] **Aled Roberts:** The evidence from last year shows that there were problems with health boards meeting their targets and some of the tables refer to the postponing of what were referred to as 'high-risk decisions'. Do you accept that there was then a reliance on non-recurrent savings, such as freezes on staff recruitment and the deferring of purchases, which most of us had evidence of in our individual health boards? Do you accept that there was reliance on non-recurrent savings?

[192] **Ms Birtwhistle:** I do not accept that there was a reliance on non-recurrent savings. Of the savings that were made last year, which amounted to £285 million plus, my understanding is that 87% were recurrent savings. So, there were clearly some non-recurrent savings and some decisions had to be made on the basis of safety and quality as well as finance. Once again, in discussing finance, I would not be true to our members if I was not putting the case very strongly to you that their financial performance is very dependent and predicated on the fact that the priority is a patient-centred service and safety and quality. I do not want to second-guess what you are referring to, but I think that you may be referring to the temporary closure of some minor injury units.

[193] **Aled Roberts:** In some instances, they were closed for four months of the year.

[194] **Ms Birtwhistle:** I understand that there were also staffing issues. Some of those units, at the time, were sometimes seeing very small numbers of patients. I know that, for that very small number of patients, it is important, but it is part of looking at the health service in the round and at how we use our resources properly. Whether they are temporary closures or part of a longer term programme of service change, we have to ensure, at a time when we are strapped for cash, that we are not providing services or tying up resources in a hospital that might be seeing two or three patients a day in a particular department when those services and staff could be redeployed elsewhere.

[195] **Aled Roberts:** Does the fact that those same units are now being closed this year

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indicate that, perhaps, the management control and forward planning are not as good as they should be?

[196] **Ms Birtwhistle:** No, I do not think that it does. I do not want to bat away every question to be answered by my colleagues, but you will have the chance to ask that of them when they appear before this committee. I do not think that it is about poor management. It is about looking at the resources that are available, looking at how those resources are allocated, looking at the demands from local populations and from politicians, looking at service-change plans—and we have not really talked about those, but they are an important part of—

[197] **Darren Millar:** We will come on to those in a few minutes.

[198] **Ms Birtwhistle:** I am sorry; I do not want to jump the gun, Chair.

[199] The fact is that all of this is happening at the same time as all the health boards have either consulted upon or are undertaking pre-consultation engagement on major service plans. This, in turn, although they will not deliver in-year savings, will make a change to the health service, which will make it more sustainable in the longer term.

[200] **Julie Morgan:** Why are the health boards struggling to deliver the intended workforce reductions and savings in the short term?

[201] **Ms Birtwhistle:** The changes to the workforce are really tough. Once again, it may be—and I may be speaking out of turn here—that we have been a bit overambitious in looking at workforce change, because workforce change is dependent upon service delivery, service provision and finances. It is a bit like a three-legged stool, really; we cannot change one without changing the other, and if we change one too soon, it has an impact, sometimes a detrimental impact, on another element of it. A lot of work is taking place on workforce planning and workforce change. We have to look at the workforce in a wider context. As the largest single employer in Wales, the NHS has a responsibility in terms of the economic health of the communities in which many of these people work. That is not to say that the NHS is here just to provide jobs for people, as that is clearly not the case. However, we cannot expect service change, service improvement and quality improvement without subsequent investment in the workforce.

10.45 a.m.

[202] It is about making sure that the skills of the workforce are appropriate and that workforce planning, which can have a very long-term effect and impact, is tied in with service change. There is an acceptance that some of the workforce changes have not happened as quickly as they might. There is a lot of work by trade unions and Government on the future shape of the workforce and the vision for the NHS regarding the type of workforce that we want and need, not just looking at this year, two years or three years ahead, but 10 and 15 years ahead, because a lot of that goes back to the training that people are having now.

[203] **Julie Morgan:** Do you think that a reduction of 2% will have an impact on patient care?

[204] **Ms Birtwhistle:** I am not an expert on the workforce, but from looking at it in the round, you cannot simply take people out of the workforce and expect things to carry on in the same way. However, other changes can be made in the way in which the workforce is managed and services are delivered. Things like overtime and enhanced payments were referred to earlier, and that is about making sure that the right people are in the right place at the right time, that the overlaps are appropriate, and that people are properly trained to go out to do different things because we now need more people to work in the community. We are

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asking a lot of many sectors of our workforce, and, as I say, there is a responsibility on the public sector, but there is a wider responsibility to the economic health of communities.

[205] **Julie Morgan:** Can you point to any area where you feel that this reduction in workforce will diminish patient care?

[206] **Ms Birtwhistle:** I think that patient care is changing and, therefore, the workforce has to change to deal with that. If we were just to take a certain number of people out of the workforce because that is what we had to do to meet the demands, I think that you would see an impact on patient care, but that is patently not what we are doing. It came out in the report that the changes have not been as rapid and the reductions and savings have not been as marked in the workforce as we might have hoped. That is for a good reason, because we are making sure that we have the right qualified people to maintain the quality of care. I make no apology for going back to saying that the priority in all the work that is being done on the workforce and every other element of efficiency savings is to do what can be done without impacting detrimentally on the quality of patient care. We have to put patients first.

[207] **Julie Morgan:** That is not being jeopardised, is it?

[208] **Ms Birtwhistle:** The fact that we are not seeing the changes happen as rapidly as we might have hoped indicates that it is not, because those things are being taken into account.

[209] **Julie Morgan:** I have a final question. How well linked together are the service plans, financial plans and workforce reduction plans?

[210] **Ms Birtwhistle:** I think that they are very well linked in. Again, I am not party to all those discussions, but very robust planning mechanisms are in place at a local level, on the ground, and at health board level, which feed back into accountability for an all-Wales workforce planning picture. That is very important, because we are looking at an all-Wales picture over the next 15 to 20 years.

[211] **Aled Roberts:** Given the controls on overtime and recruitment that you alluded to, are you able to advise us of the cost to the Welsh NHS of the pay protection packages that have been agreed to date?

[212] **Ms Birtwhistle:** No, I am sorry, but I am not aware of that. That is a policy on which we would have no influence. It is a policy that was set for all staff in the NHS, however many years ago it was. It is my members' job in the NHS to work within the policies that are set.

[213] **Darren Millar:** The director general said that he will pass on some information to us on that in any case.

[214] **Jocelyn Davies:** You stressed that patient care has not been jeopardised, and so on, but the Welsh Government's evidence paper to us said that, this year, it is becoming,

[215] 'increasingly clear that the NHS is struggling to maintain required performance standards within their current allocation'.

[216] In what areas are the health boards struggling to maintain the required standards?

[217] **Ms Birtwhistle:** I think that health boards are struggling generally to meet financial targets. One of the reasons that there is this huge pressure on finance is that there is also a determination to maintain performance in key areas. We are struggling, I suppose, with the numbers who are coming to the front door. Those numbers are higher than we have ever seen before and higher than anticipated. Therefore, it is important that those people who come to

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the front door get the appropriate treatment, care and attention. Sometimes—and this is not the fault of the individuals or the patients—the problem is that they should not be coming that far. We should have mechanisms in place—and I hope that we are doing that now through service change—to stop some of these people getting as far as hospital because it is not the best place for them. One of the tenets of improving services is that we deliver more care closer to home. At the moment, there is probably an imbalance in the ability to do that simply because we do not have mechanisms in place.

[218] Again, it sometimes helps to give examples, if I may. Abertawe Bro Morgannwg health board, for example, has a multidisciplinary team. This sounds a bit like a television programme, but it has a 'who's in our bed' audit. It identifies patients in beds in real time who probably should not be there, and I stress that that is not the fault of the patients. Those people could receive care more effectively outside hospital, either in their own homes or in a different community setting. That has meant that it has managed to close beds and reallocate the resources so that bed-to-nurse ratios are better. Joint investment with social services there means that people are being cared for more appropriately in their own homes. So, when we are talking about quality, it is not great quality for some people that they are in hospital at all. They should not be there and we have to find better and new ways of looking after them elsewhere.

[219] **Jocelyn Davies:** I do not disagree with what you have said, but the Welsh Government paper said that the NHS is struggling to maintain the required performance standards. You mentioned financial targets when I asked you which ones it is struggling with. What other performance standards is the NHS struggling to maintain? I take your point that people might be inappropriately admitted to hospital, which is not their fault. They probably do not have any other choice—

[220] **Ms Birtwhistle:** No, absolutely—

[221] **Jocelyn Davies:** —because I do not know many people who would choose to go into their local hospital if they had another choice. So, what are these performance standards that the Government says the NHS is struggling with? Perhaps we should ask the Government.

[222] **Ms Birtwhistle:** Yes and, again, there will be an opportunity to talk directly to the health boards. However, I read that as meaning that there is pressure across the board to maintain standards and meet targets. However, the health boards are still driving performance in the right direction and improving the quality of care, and that is having an impact on finances. There are all these different types of targets and standards to balance.

[223] **Jocelyn Davies:** Do you think that any of the Government targets should be revisited in light of the fact that finances do not allow local health boards to maintain them?

[224] **Ms Birtwhistle:** I do not have that sort of insight. One of the things that we are saying as the health service is that we need to look at everything in the round. Certainly, some of these issues might come out in the publication of the mid-term review next week. That will be critical in looking at where the health service is at the moment and what needs to be done over the next six months.

[225] **Darren Millar:** We have seven minutes of this meeting left and three questions that still need to be asked, so I ask Members and Helen to be brief. Mike is first, then Jenny and then Oscar.

[226] **Mike Hedges:** I will be brief, Chair. Is there sufficient clarity with regard to how much reconfiguration plans are going to cost and how this is going to be paid?

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[227] **Ms Birtwhistle:** Reconfiguration and service change are obviously under way. To fly the flag for the health service, since I came here in February, a huge amount of work has been done and progress made in that area. The driver for service change is quality of service. We have said many times, as have our members, that change would have to be made in any event because we are not delivering a consistent high standard of service across Wales. There is too much variation in the way that services are delivered; sometimes because of the way that they are reconfigured. Finance is a factor in service change. I think that we would be foolish not to make that point—and you would not expect me to say anything different. The health boards know that service change has to be delivered within the finances that are available. That has not changed. The fact that service change is reasonably well advanced now is just remarkable. It is a case of hearts and minds, really. Affordability is a big issue, and it is one that health boards are looking very closely at. Again, service changes and decisions, I am sure, will not be made without taking into account the current and future financial positions.

[228] **Jenny Rathbone:** How well do you think the seven health boards are doing in taking the clinicians and the public with them on the need for change? We have heard from David Sissling that the south Wales health boards have spent a lot of time getting all clinicians to understand the need for concentrating specialties et cetera, but obviously they have not made the actual decisions yet in terms of recommending proposals. Do we have an actual sea change happening yet in terms of the need to do things differently?

[229] **Ms Birtwhistle:** In a way, feedback from you would tell us about a sea change up to a point. I know that there have been huge efforts and a lot of very dedicated work to engage clinicians. In every element, not just in service change, a big piece of work that has happened in the last few months has been engaging clinicians in financial work because improving quality often costs less because of the knock-on effects. So, clinicians are a major part. Staff in general and the public are a major part. You will know, because you are also in the thick of it, that service change has prompted some very impassioned pleas for services not to change. Again, we have said on behalf of our members in the confederation that it is not good enough just to say that services cannot change and that you do not want services to change. There have to be good reasons, there have to be alternative views put forward, and there has to be an understanding and a dialogue.

[230] The health service has worked really hard on engaging with the public, clinicians and staff, and I think that we can see some really positive moves forward in that area. I do not know whether it is enough, and whether it ever will be enough, but I do know that I think that we have gone beyond—and I am not talking about the Welsh health service—what has possibly been seen in the past as a case of us and them. The public, in helping us to deliver change, is our greatest asset. People feel very passionately about the health service, and, as I have said here before, I think that it is our responsibility to harness that, to help them and to give them and you confidence that the changes being proposed are ones that are in the best interests of services, staff and, most importantly, the public, the patients and the health of Wales. We are trying really hard, and we are working really hard; and I think that it has become much more of a partnership with clinicians and the public than we have seen before. So, in terms of whether we have had a sea change, I would love to say ‘yes’, but I do not want to be complacent in saying that.

[231] **Mohammad Asghar:** I think that Helen already said that she is not a financial expert, but my question relates to that a little. What do you think about this financial regime, particularly the plans for managing budgets across financial years to discourage a short-term focus on annual financial targets?

[232] **Ms Birtwhistle:** We feel really strongly about that and have said so on a number of occasions. I think that it is generally not a fantastically satisfactory regime when we are dealing with just year-in targets and year-in financial pressures.

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11.00 a.m.

[233] I think that we do need more flexibility across years, as that will allow us to plan much more cogently for future pressures. Also, if I may refer back to Aled Roberts's question and the answer to that, it would remove the need for some of the changes that have to be made because there is no choice. So, it is an absolute given for us; we are really pleased that the Government is working on that, and we will work with whatever regime it puts in place.

[234] I would just say that we are also very aware that that does not take away the responsibility to work within budgets, and I want to stress again on behalf of the members that this is not a case in which there may be more money for us or different ways of getting more money; they know that times are tough for everybody in public service. We understand that the money is the money and that we have to find ways of managing within the resources that we have. So, it would not change that, but it would allow our members to think more imaginatively and plan much better over periods of time.

[235] **Darren Millar:** Okay. On that note, I am afraid that we have to close the meeting. Thank you very much, Helen Birtwistle, director of the Wales NHS Confederation. We appreciate that.

[236] **Ms Birtwistle:** Thank you, diolch.

11.01 a.m.

Papurau i'w Nodi
Papers to Note

[237] **Darren Millar:** We have a couple of papers to note. I will take it that they have been noted. With that, we close the meeting. Thank you.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.01 a.m.
The public part of the meeting ended at 11.01 a.m.

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