Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 4 Rhagfyr 2012
Tuesday, 4 December 2012

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
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

Mary Burrows	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Chief Executive, Betsi Cadwaladr University Local Health Board
Adam Cairns	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Chief Executive, Cardiff and Vale University Local Health Board
Mark Jeffs	Swyddfa Archwilio Cymru Wales Audit Office
Geoff Lang	Cyfarwyddwr Gofal Cychwynnol, Cymuned a Gwasanaethau Iechyd Meddwl, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Director of Primary Care, Community and Mental Health Services, Betsi Cadwaladr University Local Health Board
Kevin Orford	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Financial Director, Cardiff and Vale University Local Health Board
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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.

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 Members to switch off their mobile phones, BlackBerrys and pagers,

because these can interfere with the broadcasting and other equipment. The translation is available on the headsets via channel 1, with sound amplification for those who require it on channel 0. In the event of an emergency, please let us ensure that we follow the instructions of the ushers, who will guide us to a safe exit.

[3] We have not received apologies this morning. Two Members have yet to arrive, but I think that it is important that we get on with our meeting. We will move straight onto item 2 on our agenda.

9.03 a.m.

Cyllid Iechyd—Tystiolaeth gan Fyrddau Iechyd Lleol
Health Finances—Evidence from Local Health Boards

[4] **Darren Millar:** This work is being done in the context of the Wales Audit Office report on health finances, which was published in July this year, and there is also the update note that the auditor general has provided for us. We have already taken evidence from the Welsh Government and from the NHS Confederation. This morning, we shall take evidence from the Betsi Cadwaladr University Local Health Board and the Cardiff and Vale University Local Health Board.

[5] We have a video link established, and all appears to be going well so far, with Betsi Cadwaladr. So, we go live to north Wales to discuss these issues with Mary Burrows, chief executive of Betsi Cadwaladr University Local Health Board. Good morning, Mary.

[6] **Ms Burrows:** Good morning.

[7] **Darren Millar:** We also have Geoff Lang, the executive director of primary care and mental health services.

[8] Mary, you are more than welcome to make any opening remarks you may have on this particular issue if you want to, after which we will go into questions from Members. Over to you.

[9] **Ms Burrows:** Thank you, Darren, and bore da. I am sorry that we are not with you today. I am afraid that it is my fault, as I have just driven back from holiday and did not get in until late last night, so I was not able to turn around and get down to Cardiff this morning. I have Geoff here with me, because he is actually the deputy chief executive. He covered for me when I was off for four months having cancer treatment earlier in the year. So, it is important that Geoff is here to answer any questions that you may have about last year and our position coming into this year. I just wanted to set that context for you.

[10] As for my opening remarks, I am grateful to the committee for asking for our evidence this morning. We hope that we can have a really good conversation with you. I would also like to make a couple of comments on how much we welcome the Minister's mid-year review and await the outcomes of that. We also welcome a review of the financial regime of the NHS to put it on a more flexible and stable footing.

[11] I would also like the committee to note that this health board has met its financial and non-financial targets since it was set up, as did its predecessor organisations before that. During the five years that I have been here, we have met our financial duties as well as our other quality and safety duties. So, north Wales finds itself in a rather uncomfortable position and this is quite difficult for us in terms of making sure that we provide the best care within the resources that we have. It is important that the committee understands that. We knew that last year was challenging, and we were able to achieve not only our targets, but financial

balance, but we also knew, coming into this year, that it would be even more difficult. You will see that from some of the comments made by the Auditor General for Wales.

[12] The last point that I would like to make to the committee, Darren, as a marker, is that the main factor that impacts on healthcare spend is the age structure of the population, so we would like to give you some information on that. For example, we have the highest older population in Wales in the over-55, over-65, over-75 and over-85 age groups. We should not forget that deprivation is an issue that impacts on healthcare and its cost, and we have underlying morbidity and socioeconomic deprivation. We do not want the committee to lose sight of our sparsity and rurality, which impact on healthcare in terms of diseconomies of scale, so we sometimes have higher costs where we have to provide in areas to meet local need. At this point, if that sets the context and the scene, I am happy to take any questions, as is Geoff.

[13] **Darren Millar:** Thank you very much for that, Mary. We appreciate you being with us as well, Geoff, to give us more of the context during the current financial year. We know that the environment is very tough financially. The auditor general has pointed out, quite rightly, in his papers that the NHS in Wales is facing the toughest financial settlement of all of the UK nations. What practical measures are you taking on the ground in order to meet this financial challenge? What changes are you imposing on services?

[14] **Ms Burrows:** I will turn that question around and put it slightly differently: how are we trying to make the best use of the resources that we have? So, I will answer part of that and then I will hand over to Geoff to look at some of our savings and what we have delivered.

[15] On good housekeeping, you will see that the auditor general made reference to that and you can always do a bit more. We have probably done quite a lot, but I will say that there is still more that we can do on that. We are again pushing on issues about productivity and efficiency; we know that if we can get more out of that and out of the workforce in terms of its contractual obligations, we can make some savings that way. If I am honest, one of the biggest issues has been trying to make some of the changes and get the productivity and efficiency out, yet, at the same time, we are seeing such a high increase in demand because of the population. We have been putting in place good internal controls and a lot of those sorts of things that you would expect us to do, and starting on a programme of service change. You will know, Darren, that we have been on this journey for a number of years and have made some changes already in north Wales to improve the safety and quality of care, and also to make sure that we use our resources in a better way.

[16] **Mr Lang:** On some of the detail, there are quite a few areas, as Mary alluded to, where we can make savings and improvements without having to change fundamentally the service that we offer to patients and, indeed, sometimes it improves. So, in workforce areas, we are looking hard at locums and agency staff, which is a challenge for us. The use of locums is not always a good indicator of a quality service, but that is very much reflective of the geography of north Wales and of the need to have good access to services and to maintain emergency access. We are working hard on that, and we have had some successes. So, in areas like mental health, obstetrics and gynaecology and anaesthetics, we have managed to reduce our reliance on locums. There are other areas, particularly around the middle grade and with some of the issues there, where we are challenged. We are also looking at the way that we use our staff: the way that we roster staff, the efficiency and effectiveness of that; the skill mix et cetera; and premium pay. So, there are ways in which we can drive our cost base down that are not about impacting directly on service.

[17] Other brief examples to mention are estates—we are driving hard on the rationalisation of our footprint and making sure that we are efficient and effective in that area—procurement and other areas of support. So, not everything is about service impact.

Service change will become more and more important as we, year on year, eke out more savings, but actually you have to begin to challenge the fundamental models of how we are delivering our care. There is a lot that we can do in cost effectiveness, as well as the service model.

[18] **Darren Millar:** You mentioned earlier, Mary, in your opening remarks, that there had been increasing demands on the service because of the age profile in north Wales. Was that not entirely predictable, that you were getting an older population, and that, therefore, you ought to be able to plan for that? Did the Welsh Government recognise that that was going to be a demand and make extra resources available to you, for example?

[19] **Ms Burrows:** I cannot answer for the Welsh Government in that whole context, Darren, but it did make money available last year, which you are aware of, to help with some of that increase in demand. Of course, we have done a big demographic profile of the health board area and have been working towards trying to address that. We know about the burden of disease, for example, as the population age increases. We know that we will have more cases of cancer, so we have been planning how we are going to try to do that and use our resources in such a way as to try to skew them more towards the elderly, so that we can meet some of those needs, and we are working with social services. The Welsh Government did recognise that there were pressures on the system last year, but you know that. We are hoping that the mid-year review will help—

[20] **Darren Millar:** I suppose that what I am trying to get at here is that obviously we want to look at putting the NHS on a sustainable footing going forward, and we are looking ahead to the next few years. Do you think that the Welsh Government recognises the difference in demands between health boards, given the fact that your health board has a particular demographic demand and you have the rural sparsity element? Not all health boards are like that. We will be talking to Cardiff and Vale University Local Health Board later on; it has a set of different challenges. Do you think that the way that the Welsh Government calculates the basis for the cash that it gives you is fair, and that it recognises the demographic demands and the rural sparsity demands within your local health board area?

[21] **Ms Burrows:** The way that I would answer that is that it is one of the reasons why, I suspect, it is looking at the financial regime, in terms of making sure that the allocation is flexible enough to adjust to population changes.

[22] **Darren Millar:** That is the indication that it has given to you, is it? Have you had an assurance that it is looking at rural sparsity and demographics as part of the mid-year review?

[23] **Ms Burrows:** I cannot answer in terms of the mid-year review. I can say that it is looking at the financial regime, which I would assume would take account of some of those issues, and of course all of us—Cardiff and Vale, Hywel Dda LHB and the others—will be putting in our views in terms of population and demographics. As you said in your opening, this is a UK-wide problem, not just a Wales problem.

[24] **Darren Millar:** Just in terms of the forecasts that the auditor general has in his mid-year report, one thing that is interesting is that the worst-case outcome for Betsi Cadwaladr LHB is exactly the same as the most likely and the best-case outcome. Are you being very optimistic in terms of the information that you have been able to provide the Welsh Government and the Wales Audit Office, or can we take these figures with a pinch of salt?

[25] **Mr Lang:** The figures that were included in the auditor general's letter were at a point in time in September. In our reporting to the Welsh Government, what we have said is that we still envisage our position being at the £19 million at this point in time. We are working very hard to reduce that, but given the risks that we have assessed, we now have a

range that could take that to £24 million if we are not able to manage the in-year risks. We have put a more sophisticated analysis of risk around that in our most recent reporting to the Welsh Government and we are in dialogue with it on how we are managing those particular risks to ensure that we deliver £19 million and below.

[26] **Darren Millar:** However, potentially, it could drift even further up to around £24 million.

[27] **Ms Burrows:** Well, we hope not.

[28] **Darren Millar:** But that is your worst-case scenario, is it not?

[29] **Mr Lang:** If all of the risks were to move in the wrong direction then, potentially, yes, it could drift. We do not envisage that being the case because we are working very hard to manage those risks, but in direct response to your initial point, which was that it seems strange to have a high and low the same as your mid-point, our worst exposure is probably up to about £24 million.

[30] **Darren Millar:** Thank you for being so candid about that. I will move on to Aled Roberts.

[31] **Aled Roberts:** Good morning. We have noticed that there was a need for the £17 million that Darren referred to earlier. What were the reasons for that extra requirement, and what action have you taken to address those issues during the current year?

9.15 a.m.

[32] **Ms Burrows:** That money was used to help to provide support for our emergency pressures, Aled, in terms of a lot of the influx that we had into the accident and emergency department, into medical and even into some of our surgical wards across north Wales. As you will have noticed, if you look at the A&E performance targets, for example, you will see that those pressures have not eased off. So, to try to manage that, we have been doing some work on our A&E departments. We have been able to recruit staff into Ysbyty Glan Clwyd, which was our most pressurised area in terms of having permanent staff, and we have been working to make sure that we get—and this is an awful phrase—the flow through the hospital better in terms of making sure that patients have a good experience, but that they are also seen in a timely manner and their outcome is good. So, we have been working on that as a key area.

[33] **Aled Roberts:** Okay. When did you know that you had those pressures, because we noticed in your financial predictions from last year that you were reporting that you would break even up to month 11? So, were those issues not apparent before month 11 and why did you still consider that you could break even if you had those pressures?

[34] **Ms Burrows:** That is because our obligation is to break even. We tend to use the management of risk, so we calculate along that. We were working through those issues of risk all the way through.

[35] **Aled Roberts:** Is that methodology used in all health boards? We had evidence last week from, I think, Abertawe Bro Morgannwg University Local Health Board, which suggested that it, perhaps, was adopting a more realistic assessment of its performance during the year. We noticed that that did not appear to be the case with all health boards.

[36] **Mr Lang:** That is a point that the auditor general has drawn out previously, that there is some inconsistency. As Mary has said, we are very clear within the health board in terms of

the board itself and our clinical leaders, managers and others, that our duty is to balance and therefore our challenge is to produce a plan and deliver a plan that will balance. Throughout last year, our projection was to do so. You are right to point out that, if you look at the profiles, as the auditor general has said, there are some inconsistencies that, perhaps, could be more aligned to give a clearer picture across Wales.

[37] **Jenny Rathbone:** The older population that you have is not a surprise, so it is quite difficult to understand how your previous forecasts have been so out of line with what you currently predict. So, what are you doing to prevent older people from being admitted to hospital unnecessarily, just because social services is not there or because some other service is not there?

[38] **Ms Burrows:** Thank you for that. One of the things we are doing—and I think that you will have seen this being trailed quite a lot—is work on the home enhanced care service and making sure that we are working with general practices and the wider community to try to keep people in their homes and give them some support. You are right to say that we knew that the population was getting older, and I think that some of that is about trying to get the change in the way that you run the service—and that is a cultural as well as a behavioural change—in order to try to keep people at home by giving them the support that they need, rather than the default position always being to come in to hospital, which, sometimes, is not the best place for them. You may have heard Radio 4 this morning and seen the Nuffield report, which talks precisely about issues such as these. So, we have been trying to do quite a lot of work on those community-based services, but that means a different approach in terms of what we are trying to do. Geoff has had quite a lot of experience of doing that recently.

[39] **Mr Lang:** As Mary said, it is a very important theme for us. If you look at our consultation on strategic service change, you will see that it is very much about gearing up our community services, both in terms of general support for frail older people through our enhanced care scheme and the major strand that we have on older persons' mental health services, which is very much about releasing resources from bricks and mortar and having strong community teams that can support early diagnosis, provide support in the home and wrap services around an individual and their family to ensure that we are less reliant.

[40] In terms of relationships with local authorities and social services, we are not bedevilled by a great problem of a lack of co-operation and joint working with local authorities. So, we do not have major issues in terms of hospitals facing undue pressure because of gaps in social services. However, it is a growing issue, and it is one that we need to address for the balance of our services. That is very much what our consultation seeks to address.

[41] **Jenny Rathbone:** We heard last week that one of the other health boards—I think that it was Aneurin Bevan Local Health Board—is doing an audit of 'Who is in our beds and why'. Are you doing that type of thing?

[42] **Mr Lang:** We have previously undertaken audits, particularly in relation to two aspects. One is presentations at the front door—whether people are coming to the emergency department via ambulance or are self-presenting, who could have had alternative services. We are looking very much to ensure that we have good ambulatory care and assessment, so that people can be assessed and do not need to be admitted to hospital. Where it is about signposting people back to the community and spotting gaps, some of our enhanced care has been built up to respond to those very issues, where we perhaps have older people at home who need some element of more intensive support and care that runs beyond the normal working day. If we can provide that in the community, it will avoid admission. We are also looking at the flow through the hospital and the routes out of hospital, and the degree to which community services are coming into hospital to take people out. So, we have done

similar work, but probably not in a structured audit as you referred to. However, understanding those issues and ensuring that alternatives are in place is very much our strategy in terms of pre-hospital care and early discharge.

[43] **Jenny Rathbone:** These issues are not new to the last six months. How can you convince us that you are transforming these services quickly enough to meet your financial objectives?

[44] **Ms Burrows:** That is a really good point. It brings me back to the point about cultural and behavioural changes. In terms of the older persons mental health work, that means changing institutional perspectives by staff and the public of how we care for people into one of providing really good support and a better quality of life in the community. As you will probably know, these things do not happen overnight and do not happen quickly.

[45] Having said that, we understand that there needs to be a whole pace—we talk about pace quite a lot within our health board—behind all of that, to get people to take a leap of faith and to feel confident that what we are providing is even better in terms of what they are doing. If I am being honest, it is difficult for us to try to match the pace, look at the resources and make sure that we are getting the quality of safety standards that we need to do that.

[46] So, I can only give you as much assurance as I have confidence in terms of what we are trying to do and the evidence base that we have so far. However, we all know that it needs to go much quicker and that we need to bring communities with us, as well as our staff, in order to do that. Politicians and leaders within communities have a big role to play in that—it cannot just be done by the NHS.

[47] **Jenny Rathbone:** That is noted. On the detail, what impact, if any, is the need to commission services from England having on your financial planning and current position?

[48] **Mr Lang:** In terms of headlines, we have a varying strategy in terms of the relationship with England. In some areas, we are seeking to repatriate services to north Wales, because we believe that we can offer those more locally and more accessibly. In some instances, that has no financial impact, in that it is cost-neutral. In other areas, we have managed to do that at a saving, by releasing the money at the tariff rate that is applied in England and investing at a local rate. That has helped us with our financial plans.

[49] In terms of our overall access to providers in England, we have worked very hard to manage those contracts; we have pulled savings out of those contracts by managing them very hard and very effectively. Where there has been a requirement for resource—and it has been managed within the overall plan—is to hit access times. We have been very clear that, wherever the population in north Wales accesses services, a similar standard should apply. So, our commitment to delivering 95% in 26 weeks and absolutely no 36-week waits is applied in England as well as Wales. That brings a degree of demand and pressure, but we are managing the contracts very well, we have managed to make savings and we, as I say, are actively trying to repatriate work where it is safe and appropriate to do so and where it presents value for money, because bringing it back at a cost premium is a huge challenge. However, we have not done that; we have managed to release resources in many instances.

[50] **Jenny Rathbone:** Thank you for that answer. The Minister for health has been clear, up until recently, that there is no more money. We heard last week from David Sissling that there is a contingency fund that looks as if it is going to help health boards in this financial year. However, it is clearly not enough to cover the £19 million in Betsi Cadwaladr and all of the other cost pressures. So, what is the plan? What is going to happen? What is the Welsh Government saying to you that is likely to happen, if you continue to have a £19 million deficit?

[51] **Ms Burrows:** You would obviously expect that we would be fighting our corner in terms of making sure that we can get resource, but also recognise that we are part of a greater NHS and that other health boards will need some support as well. We know that there might be an opportunity—I suppose that I could use that word—for us to borrow into next year, which is not something that we want to do. I know that that was what some other health boards did last year, but our financial regime, as you know, does not allow us to raise or carry forward money, like local government, that would raise any sort of income. We have to make sure that we land the plane on the stamp, which is quite difficult.

[52] We very much support some of the flexibility in the financial regime that the Welsh Government is considering, so that we can make sure that all of NHS Wales achieves its financial duties, and where we need to help each other out, we can do that. However, in direct answer to your question, we are aiming to try to get below £19 million and we are trying to get as much support as we can from the Welsh Government, while being mindful of the others. Unfortunately, if we have to borrow into next year, we will do that with a heavy heart, but I need to make sure that this health board contributes to the rest of NHS Wales to make sure that it achieves its statutory duty.

[53] **Jenny Rathbone:** Thank you for those clear answers.

[54] **Darren Millar:** Just before I bring Gwyn Price in, does the cross-border service side of things pose any risks to the health board? Given the changes that are happening in England, is there potential for a sudden cost increase, service relocation or service change pattern in England having a knock-on impact for Welsh patients from north Wales?

[55] **Ms Burrows:** I will start and then bring Geoff in, because he is doing a lot of work on cross-border issues. Yes, there is a potential impact, because where we used to deal with primary care trusts, we are dealing now with GP consortia. There are issues about how they may want to use the market. I think that I have said before in many public fora that our upper gastrointestinal cancer service based at Wrexham has a large catchment population, which includes the Wirral and parts of Cheshire, and if the GP consortia decide to compete with others, we could potentially lose some of that service, which would have a direct impact on the population of north Wales. When you provide specialised upper GI cancer services, you need to make sure that you have the volume to do that. So, there are issues, which we have raised through a number of routes. Like I said, Geoff is on the cross-border group, so he might want to add something to that.

[56] **Mr Lang:** I have two or three things to add to what Mary has touched on. We get income from English commissioners for services that we provide as a health board. If the commissioning consortia take different decisions, that potentially is a risk to us, so we need to work closely on that. In terms of our expenditure, I do not envisage, in the short term, that the changes present particular risks, because the basic tariff structure and the way that we pay for care remains unchanged. However, what we cannot predict is the service change that will flow, for example, if the commissioning consortia take decisions to remove services from certain hospitals over the border that have traditionally supported our population. So, we need to be a part of and engage with those discussions. We are picking that up in terms of our planning to try to ensure that we have intelligence on the prospective plans of other commissioners. So, there is a risk of the unknown at the moment that we need to work through as the changes bed in.

[57] **Ms Burrows:** It is worth saying that we are a big contractor in relation to some of these services in the north-west of England and, as a health board, with a £1.2 billion budget, we have some economic power in terms of making sure that we can get the right sort of tertiary and specialised services. So, it works both ways. We have been very mindful of that

all the way through the changes as they started to progress in England.

9.30 a.m.

[58] **Gwyn R. Price:** Good morning. Why are you behind with your original savings plans and what are you doing about it?

[59] **Ms Burrows:** Thank you for that. Geoff? [*Laughter.*] We have just gone back through the figures, so Geoff has those.

[60] **Mr Lang:** Thank you, Mary. We set out our original savings plans at the beginning of the year and, as the auditor general noted in his update report, in September we looked at those savings plans and we changed some of the data. The graphs in the report represent the pre-September profile, but there is a footnote that says that there was a change. The reason for that change is that some of our savings plans were slow to get off the ground. That is something of which we are very conscious. We worked hard this year to achieve a greater level of savings earlier in the year and to make sure that we could save more throughout the year. However, we recognise that we have to be better at that. We are now in the process of looking at our savings for 2013-14.

[61] So, there is something about the way in which we, as a board, organise and manage and how far we look forward in terms of our savings. Some of it is about organisational maturity in profiling, and some of it is about the fact that we realised that some of those savings, for example in locum and agency staff, would not be realisable. With the changes going on with the deanery and with some of the issues in relation to immigration and recruitment difficulties, we had to remove those savings targets and replace them with others. Inevitably, that brings an element of drift, because the new savings can only be profiled later in the year. So, some of it is related to the way in which we plan. If you look at our profiles for the last couple of years, you will see that the proportion of savings coming through in the early part of the year is increasing and our quantum is increasing, but we still have a quite a low proportion—between 1% and 3%—in April. That needs to be higher. We need to be off the blocks quicker and that is something that we recognise as a health board. So, there is a mixture of issues there. At the moment, running through to October, we have saved about 47% or 48% of our savings target, which is better than was the case previously, on a larger sum. However, it is still not at the more than 50% that you would expect if we were running through the year.

[62] **Gwyn R. Price:** Have you made, or do you intend to make, outright cuts to services in order to make savings and improve your financial position?

[63] **Ms Burrows:** We are not in the game of making outright cuts to services. We are trying to make sure that we can provide care in the best way that we can for the greatest population. On occasion, that will mean that we will have to consolidate some services into areas where we have a lot of pressure. That is not a cut to a service; that is just reprofiling what we are trying to do. We have had to do that—[*Inaudible.*]—those services back in at a later date. We should be in the position that we were in last year. That was not, by the way, about money. There is an important point here. Sometimes, we do it on the basis of safety or where we have staff sickness. It is not necessarily an issue about trying to save money; it is about safety of care. I do not want the two to be conflated.

[64] **Mr Lang:** Some of the changes to services that we have been looking at are sometimes construed as cuts. We have looked very hard at the evidence on what is good and effective clinical care and we know that, within our organisation, it is not uniformly applied. So, in terms of looking at the evidence base and saying which services we should commission in what volume for which groups of patients, that is having an effect and changing how we

deliver services. Some may view that as a cut, but we would view it as responsible use of resource in accordance with clinical evidence and what our clinical body is saying to us. The other thing about some of our services is that we can change a lot in terms of how we deploy our workforce, its grade mix and skill mix, which means that there is a lot of change involved at a reduced cost, but not necessarily a cut in service. That is an important balance that we are trying to hold as we move through our financial and service planning.

[65] **Gwyn R. Price:** Has the Welsh Government provided you with sufficient support and direction to help you to bridge your funding gap?

[66] **Ms Burrows:** In which way? How do you mean?

[67] **Gwyn R. Price:** It is in the question. Has the Welsh Government provided you with sufficient support?

[68] **Ms Burrows:** It has provided us with support in terms of looking at how we can help manage our finances and some of the work that we are doing. It has put in support around the delivery support unit to help us improve our productivity and efficiency, so it has been very supportive in terms of helping us improve our pathways and some of the safety and quality of work that we are doing.

[69] **Mr Lang:** For me, in terms of the direction, there are two aspects to that. One is that, yes, the expectations of Welsh Government were quite clear and issued very early, which is helpful because that allows us to plan our year. The other important area is the strategic direction and encouraging us as health boards to look at the strategic configuration of our services. That, I think, gives a clear steer to the NHS in Wales about how it needs to change services and to move together as an NHS and engage with the public. In the mid term, 'Together for Health' and the strategic direction are helpful to us in terms of our service and financial plans.

[70] **Darren Millar:** During the financial year, in terms of the savings profile and the fact that there was an increasing difference in the savings profile compared to targets and achievements, at what point did the Welsh Government step in to give you additional support as an organisation to help you get back on track?

[71] **Ms Burrows:** Are you talking about last year, Darren?

[72] **Darren Millar:** No, I am talking about this year. You said you that you had had support this year. Has that been throughout the year, or has it stepped in part way through in response to the situation that you are in?

[73] **Mr Lang:** It is a mixed picture. In some areas, we have had ongoing support as part of our regular relationship with Welsh Government. In other areas, for example, in terms of unscheduled care in Glan Clwyd, which is more of a service pressure issue than a financial one, that was an area where we knew our performance was not good enough; the Welsh Government noted that and demanded of us, quite rightly, an improvement in performance and offered us support to enable us to do that. So, it varies. There is a background level of support and a generally supportive relationship with Welsh Government officials, and then, if there are particular performance issues, mainly around service—not financial issues in our particular perspective—we have had targeted help and assistance, which is geared towards delivering to the clear expectations and directions of Welsh Government.

[74] **Mike Hedges:** I have three questions. First, I do not understand, if you are making more savings at the end of the year, why the full-year effects coming in are not beneficial. Could you give an update on progress regarding workforce savings and staffing reductions,

and, thirdly, how important are social services, housing and other services to health?

[75] **Mr Lang:** In terms of our savings profiles, there are elements of our savings that have had full-year effect in this year, so we knew that—I am grasping for the figure now, but it is double digits in terms of millions of recurrent savings coming out of last year; it is just above £10 million, I believe, although I do not have the specific figure with me. So, some of those savings that start early on in the year were coming through this year, and then, in addition, we have added further savings again to assist us moving forward. It is also important to recognise that, in some of the areas where we make savings, other pressures will emerge, such as locum doctors et cetera. So, we may well have made savings, but, as further pressures emerge, those savings get suppressed in terms of their impact in the next year. We have had examples like that where we have made progress and then other pressure has depressed the impacts of those savings in the next year. However, significant sums were coming forward and those have been realised in this year.

[76] **Ms Burrows:** I will take the next one, which is workforce savings. We have not been as good as we wanted to be on our workforce savings. I think you will find that that will probably be the case with other health boards. There are a number of factors that play into that. One is that our turnover used to be around 9% or 10%. That has now dropped to around 5%. You would expect that. You would have less churn in terms of your staff because of the economic climate and job stability. Job security is a really important factor. So, that is one thing. We do not have the pool of people that we would normally have, which would sometimes give us an opportunity to look at how we might want to change our skill mix or the way that we provide services.

[77] There are also issues about consultation and negotiation with trade unions that we need to consider. Those things take time. Where we do change services there is usually a three-month consultation, and we also need to make sure that, where agreements have been reached, terms and conditions are still honoured. I think that there is a question for the committee in terms of whether the contracts—'Agenda for Change', the consultant contracts and the primary care contracts were negotiated on a UK basis, although, having said that, consultant contracts are different in Wales—are still fit for purpose and are improving productivity and giving us the flexibility that we need for a healthcare system that operates 24/7. The committee may want to look at that. This is probably a harsh way of saying it, but, since 2009, when we became a health board, just over 1,000 members of staff have left. Having said that, you will see from the figures that we have flatlined slightly, simply because we have to maintain the safety of services, and so we have had to employ a few more members of staff than we would probably normally do, given some of the changes that we would make. That is about safety, which comes above everything else.

[78] You also mentioned our reliance on locums. It is important that we have a stable workforce. We have been very good in terms of getting consultants. It is in our middle grade, in order to keep services safe, and on our emergency side that we need to make sure that we have staff in place. Unfortunately, Wales is third or fourth in terms of the lowest number of doctors, nurses, midwives and health visitors of the four UK countries, and north Wales is the lowest in Wales. So, we are starting from a low base, and so we still have that reliance. We have not been able to make some of the workforce changes as a result.

[79] It is a quite complicated picture. If I add the deanery on top of that, to which Geoff has already alluded, that complicates things a bit more. Trade unions are very engaged in trying to make changes, but overall it has been much slower and harder in some respects than we would have liked. That also applies to the employees. We do not want to forget that.

[80] **Mr Lang:** The final point, I think, was around social care and housing, which is obviously hugely important. As Mary alluded to earlier in terms of our future plans and our

home enhanced care work, we are doing a lot of work with local authorities on mental health and learning disability services, trying to improve the collective offer between agencies in terms of how we support service users in those areas, and particularly in terms of the frail elderly, which is a particular challenge for us. I think that there are some more testing areas in terms of the older persons mental health agenda and dementia, where sometimes our services are not aligned as they might be, because our services fall within the mental health brief and, in social services, they often fall within the broader older persons area. So, there are some areas that we need to work through. As I alluded to earlier, I think that we have a good relationship with local authorities. There is a genuine commitment to develop that. Increasingly, that commitment is to work across north Wales, which is very helpful to us. We found it very challenging working with six different local authorities in six very different systems, at times, and we are finding the local authority collaborative agenda coming together. It is helping us in shaping some common principles and approaches to how we want to deliver care across north Wales. I think that that will deliver value in terms of service benefit, but also financial benefit. For example, we have collaborative procurement arrangements with local authorities that are seeking to drive the costs of external placements and high-cost packages down. That has been quite beneficial, and it involves social services and very much a housing input too.

9.45 a.m.

[81] **Aled Roberts:** To go back to the workforce issues, I accept that you have experienced recruitment challenges in certain areas, but the figures that we have show that you were looking to reduce staff by 230 whole-time equivalents, whereas the information that we have is that your staffing has increased by 111 full-time equivalents to date. Historically, has north Wales been over-reliant on locum and agency staff due to the culture within the organisation of keeping staffing levels low? I am thinking of some of the stuff that we did on neonatal care, for example, in the Children and Young People Committee. Historically, there had been no attempt to recruit consultants, and so there was a reliance on locums. I also wish to ask you a question that I asked last week to NHS Wales: what is Betsi Cadwaladr LHB's bill as far as its pay-protection agreements are concerned?

[82] **Ms Burrows:** Regarding the figures of 230 and 111, I recognise the latter, which was in the auditor general's report. My recent workforce information was that, since 2009, we have reduced our headcount but, as I said, we have also flatlined. Some of the numbers have gone up, perhaps as a result of junior doctors coming in. Also, we have had to invest in unscheduled care nursing, which you would expect us to do. That is particularly the case in Wrexham, I might add. That is to ensure that we have safe services, particularly on the in-patient medical side.

[83] I do not recognise a culture of a planned reliance on locums. In fact, Aled, it is not a good thing to do. It does not provide continuity of care to patients. Also, if you have people coming in and out, that does not build a system of team-working, whereby you form, or become part of, a team. You will know that, the further west you go, there have been issues with recruitment—trying to recruit people into north-west Wales has become particularly challenging. Therefore, there has been a reliance on locums. One thing that I have said is that, from a safety point of view, let alone anything else—and cost is a big contributor here—we have to ensure that we have a stable workforce. We have been actively recruiting. If you look at our figures, you will see that we have been quite successful, and Geoff alluded to that at the beginning. The issue is the middle grade, simply because those doctors are not out there. A lot of the doctors at that grade came from abroad, and, because of immigration issues, we have not been able to recruit more.

[84] So, there are some choices here, and several ways to address the issue. One way is to move primarily to a consultant-delivered service. Again, you would have to look at the

numbers. Alternatively, you could have a mixture of a consultant-delivered service and changing the way in which the services are provided. So, you would specialise, as we have done in relation to cancer—gynaecological cancer, upper gastrointestinal cancer and neurological cancer. You would try to get a cohort of surgeons or specialists together, so that you did not spread yourself too thinly. I am not happy with a reliance on locums from a safety point of view, let alone from the point of view of consistency for patients. We have actively been trying to work on that and, in many respects, we have been successful.

[85] On the pay-protection side, we have the data on that.

[86] **Mr Lang:** We have, indeed. At the moment, we have 63 members of staff who are on pay protection as a result of this particular organisational change. At the moment, their protection presents us with an annual cost of £500,000 a year. That will reduce over time as each of those staff members moves to the end of their protection period. However, as we sit here today, those are the figures.

[87] **Ms Burrows:** That is 63 out of 17,000.

[88] **Darren Millar:** You have set yourself a target, as a health board, of reducing staff numbers by 230. Staff numbers have increased by 111, and you have now pushed a need to save 341 people before the end of the financial year. Are you being realistic? Were you being realistic at the start of the year, in terms of what you were expecting to achieve, and are you being realistic now, with your reprofiled picture of expecting to save 341 posts before April?

[89] **Ms Burrows:** Hindsight is a wonderful thing, as we all know. At the time, we were realistic about what we were trying to do in relation to our plans. This is about demographics, and the speed at which some of that has hit us, particularly around dementia. There is a higher prevalence of cancer and, I have to say, very sick people. You only have to stand in an accident and emergency department or go into a medical unit to find that the complexity and acuity of patients is something that very seasoned consultants have never seen before. I think that we were realistic at the time, but things have overtaken us. We have tried to address that. In terms of the 341, if you look at the current number of jobs that we have going, you will see that we have fewer than 50 at this point in time. Therefore, I am not sure whether the figure of 341 is realistic. It is a mathematical figure, actually. That is a key point, because each job has to be taken on its own merits.

[90] **Mr Lang:** I would like to add to that. On the 341 referred to in the auditor general's paper, effectively, if our plans remained unchanged, to deliver them we would have to remove 341 staff in the second half of the year. I commented earlier that we have reviewed our plans in-year and we have accepted that some of them will not deliver, so we have replaced them with alternative plans. The auditor general referred to reprofiling and a reassessment of savings plans; we had a major reassessment in September and October and we are still refining those plans, because we are acutely conscious that the plans that we have in place to deliver £19 million—and below £19 million—must be realistic and deliverable. Some of the workforce plans will now not come to fruition this year. We have to find alternative ways to save that resource and to ensure that the plans that we set for next year are deliverable from April onwards.

[91] **Julie Morgan:** I want to ask you about patient experience and quality of care. Looking back over the last six months of the financial year, do you feel that there have been any problems with the delivery of care to the patients?

[92] **Ms Burrows:** That is a big question. It is mixed. You will know that we have had ombudsman reports. We asked Healthcare Inspectorate Wales to come in and do a follow-up report when the ombudsman made his comments last year, which we took very much to heart.

Usually, on average, we get 26,000 compliments a year about the good care that patients have experienced. Normally, we hear about the care, quite rightly, when it has not been so good. We do quite a lot of work on patient experience in terms of real-time information from patients. We ask them questions—we have used a Picker survey—and we keep a really good eye on the quality of care. I hate to say this, but if you look at what is going to come out of mid Staffordshire, where the whole direction is focused, in that case, on the money and a foundation trust application, and you take your eye off the quality of care and you do not keep an eye on the safety of care—your morbidity and mortality—then you are doing a disservice. So, we watch those things very carefully, because we need to ensure that we have the balance right and that we are using our resources effectively. We need to ensure that we are addressing the burden of disease, which is important in terms of our role in public health and population health gain, and that not only are we more reliable, but that our standard and quality of care are what patients and their families and carers would expect. So, we have a number of mechanisms to look at that and when we do get concerned, we step in very quickly. If that means that we have to put in a little additional resource in order to stabilise the service, then that is what we have done, because the safety of the patient is paramount, and we then have to try to address the consequence of that if that has affected us financially.

[93] **Mr Lang:** Perhaps I could give you a practical example of that. In this financial year, one of the issues that came out of some of the work from the ombudsman and the Commissioner for Older People in Wales was the degree to which we were able to offer dignified care, particularly in terms of older people in our hospitals. That reflected, not purely on nursing, but significantly on the levels of our ward staffing and nursing. Were we at the standards and levels that the chief nursing officer and the Royal College of Nursing were endorsing? In some areas we were not and we took a conscious decision, as a board, to recruit more nurses to make sure that the quality of care was right. That gave us a difficult financial challenge, but in terms of holding that balance between quality and safety of provision and financial balance, which I believe that the health board has to do, we have taken some decisions that build more financial pressure but do so for the right reasons. That is one example of where we have done that, because we are conscious that quality cannot slip purely for financial reasons.

[94] **Julie Morgan:** Are there any other areas where you have concern that the quality is not there?

[95] **Ms Burrows:** You could probably look into any service and ask yourself that question. All our indications—through patient feedback and through looking at some of our data—show that the quality of care is at the standard that you would expect. That is not to say that it is good enough, in my view; I think that we should always strive to be a lot better. One area in particular that we have been concerned about and would have given evidence on, is Birthrate Plus and maternity services, where we have taken a conscious decision, because it is right for women to be on a normal birthing pathway, and we need to make sure that the woman gets a very good experience and the life chances of her child/children are the best that they can be. So, we have taken a conscious decision, based on looking at the quality of care and the risks within that service and the life chances of the children, to put investment into that. That has meant a financial cost to us, but it was the right thing to do.

[96] **Julie Morgan:** I think you mentioned that you had 26,000 compliments. What about complaints?

[97] **Ms Burrows:** I think the figure was around 500.

[98] **Mr Lang:** We can provide the data

[99] **Ms Burrows:** We can give them to you.

[100] **Darren Millar:** That would be helpful. It would also be helpful, Mary, if you could provide us with the figures for NHS concerns—the number of concerns, the number of formal complaints and the number of compliments. That would be very helpful. If you could give us those figures for the last few years just to see the trajectory, whether it is up, down et cetera, that would also be useful to the committee.

[101] **Ms Burrows:** I think you will find that they will be up, because we encourage people to speak up. An upward trend is worrying, but it also gives us an indication that people are willing to say something.

[102] **Darren Millar:** I think that we will try to get these figures for all the health boards to give us a pattern and benchmark. Thanks for that, Mary.

[103] **Jocelyn Davies:** I would like to ask you about your reconfiguration plans. Can you tell us how they are progressing and what you are doing to ensure that the changes will be financially sustainable?

[104] **Ms Burrows:** As you know, we have finished consultation on what we were consulting on and those decisions will not be taken by the board until January, so anything that we say has to be in the context of no decisions having been taken. It is important that the committee knows that, because we do not what the board will be minded to do. However, we have some information here to share with you around reconfiguration. I assume that your question refers to what we are consulting on.

[105] **Jocelyn Davies:** Yes.

[106] **Ms Burrows:** Thank you.

[107] **Mr Lang:** There are probably two clear strands within this. There are some services where we are consulting on change where it is very clear that this will cost money to achieve a standard that is nationally set and firmly supported by all parties. So, for example, in neonatal services, we know that, depending on which route we go down, it will cost us between £2.25 million and £3.5 million. That is a revenue cost that we will have to incur. Aled alluded to some of these points earlier in terms of the medical staffing rotas, the nursing staffing rotas and so on. That will be an investment; the board would face that investment whether it consulted on service change or otherwise.

[108] In terms of our other main areas of change, the ones where there are most resource implications revolve around the community-based services—older persons mental health and the general community services and community hospital services. What we are looking at there is an approach that will not save us money in the short term, but an approach that will rebalance the system to make sure that we have more support in the community, as we talked about earlier, for an increasingly elderly and dependent population, thereby making sure that we are more fit for the future in terms of resilience and capacity.

[109] Our savings to community-based services, in terms of minor injuries, community x-rays and changes to hospitals will release £4.98 million. Those are the savings that we estimate will come through if the decision of the board is to progress along those lines. We are looking to reinvest a total quantum of £6.38 million against that, so you will see that there is a net cost there. We believe that that is affordable. The profiling of when the savings come out and the investment is made will be hugely important to ensure that we are not in a deficit position. However, with the right community services in place, we think we will reduce reliance on hospital services—general hospitals as well as the community hospitals we have referenced—and that will release further resource for us, potentially up to £3.3 million. That

will mean, in the medium term, that there is potentially a financial gain as a result of the changes, but more importantly, it puts us on a very firm footing to be able to deal with the demand that we see coming within our resource base.

10.00 a.m.

[110] In terms of older persons mental health services, we will see savings of just short of £1.6 million and reinvestment of a virtually identical sum. So, it is almost revenue neutral—there is a marginal saving of £20,000 or £30,000 depending on how the services work. So, that is very neutral.

[111] On the capital side, there are new capital schemes in our consultation proposals that amount to approximately £33.5 million. We have had regular discussion with Welsh Government officials about our capital assumptions. We have been very clear in understanding what our priorities are and where those schemes might fit in an overall capital programme for Wales. Even though we accept that that is a shrinking capital programme, we are still fairly confident that the schemes that we are including are those that should be affordable within the current known capital constraints.

[112] **Jocelyn Davies:** On your proposed changes to the neonatal services, the extra funds for those will be found from savings elsewhere. I understand your caveat that you are not currently the decision maker and that that will happen in January. Could you say a little about the attitudes to risk? Some of these changes will lead to a loss of service in one area and extra services elsewhere, so would you deliver services in parallel for a short period of time or will you just switch from one service to another?

[113] **Ms Burrows:** In the past, we called it dual running. There was a period when you were able to do that. If we are honest, that is no longer the case. We had to ensure that we did it with the Royal Alexandra Hospital when we established the home service in the Rhyl area. We were able to switch over within a matter of two weeks, I think, in order to do that. So, you have to line everything up in terms of staff and training and then make the switch quickly so that there is no delay in services for patients. Of course, we have contingency plans in place, but it is unrealistic to say that the days of trying to dual run everything and incur costs are still here. In many respects, it is probably better that we do things in the way that we are doing them now, using the experience and evidence that we have and ensuring that we are managing the risk through that.

[114] **Mr Lang:** It is also important to say that in terms of some of our savings, if these decisions were to be supported, there are areas where we are consolidating services between sites, so that would allow us to release savings that could give us an element of lead time on some recruitment and so on. So, it would not be dual running, but it gives us more of a chance of doing a very active real-time switch from an in-patient service to a community one. We would have to be very careful in the phasing of how we release savings and in the phasing of building up our community services to ensure that we hold the confidence of the community that not too many services are being withdrawn when the others are not in place, while accepting that it is about a balance of risk and that the ideal scenario of dual running and of building confidence and then changing things is probably unrealistic in the current financial climate.

[115] **Jocelyn Davies:** You mentioned working with the local authority. Are you also working with the voluntary sector to deliver any of these changes?

[116] **Mr Lang:** Yes, particularly in our community-based services. Our home enhanced care model, where that is established, has a clear link with third sector organisations. For example, the British Red Cross is particularly active in that as well as other support

organisations in terms of people befriending services and community support for older people. Community transport services are also an important part of this. We work closely with the Alzheimer's Society as part of our planning of the older persons' mental health service to ensure that we have a good network of community services that is well connected to that which the third sector and local authorities can do alongside us.

[117] **Jocelyn Davies:** So, do you fund any services through the local authority and the voluntary sector?

[118] **Ms Burrows:** I am sorry; we only heard a part of that question.

[119] **Jocelyn Davies:** Do you fund any services through the voluntary sector or through local authorities?

[120] **Ms Burrows:** Yes.

[121] **Mr Lang:** Yes, we do. We fund services with the third sector and we have included an element of resource in our plans for that to supplement those services. It is not a huge amount of resource, but we have included it. In terms of our enhanced care, this has been a particular concern of local authorities in that they did not want to see an increasing cost burden. We have been very clear that, where we are keeping people at home who would otherwise be in hospital, we pay for that. If there is an added burden, such as in terms of social work time for more assessments et cetera, we have supported the local authority to deliver more social work. Generic care input is something that we resource and do not rely on the local authorities to provide for those cases.

[122] **Jocelyn Davies:** Thank you—

[123] **Darren Millar:** I am conscious of the time.

[124] **Jocelyn Davies:** Yes, perhaps we could have some details on that.

[125] **Darren Millar:** We are going to need to move on I am afraid, so please be brief, Jocelyn.

[126] **Jocelyn Davies:** I just wondered whether we could have a note on that particular aspect.

[127] **Darren Millar:** Could we have a note on third sector commissioning?

[128] **Ms Burrows:** Yes, of course you can.

[129] **Mohammad Asghar:** How are you addressing the problems that have hampered NHS reforms in the past, such as by involving the public, clinicians and other key local stakeholders in decision making? What lessons have you learnt that you could share with other health boards?

[130] **Ms Burrows:** If I can put it this way, it is always a learning experience. If we were to go back to look at the work we started in 2008-09 before we became a health board, because north Wales had a history of good collaborative working between health and local authority organisations, moving on to how we carried out the engagement process with local communities, there are some lessons that can be learned from that. Some of those have to do with the length of time spent on engagement. One of the things I have asked the Welsh Government to do, which it might want to consider, is look at our engagement and consultation guidance to ensure that it works very well and that we do not get into very long

conversations over long periods of time when trying to make some of the changes. This goes back to one of the points made earlier about pace, getting a good public debate about what the future of NHS services should be, and ensuring that everyone is engaged in that debate in a clear and sensible way, very much as was outlined by the Bevan commission. There are some issues around that that we would like to look at.

[131] With regard to some of our own learning, one of the key things with trying to achieve change, and particularly cultural and behavioural change, is to bring your staff with you. We have spent a lot of time with clinicians leading a lot of this work, looking at the evidence base and challenging themselves with regard to the quality of care, asking themselves whether it is of a standard that they would be happy to receive and whether they could do better. I suppose it is the same with lawyers, doctors or anyone: if you get a group of them in a room, they are not all going to agree. So, we spent quite a bit of time working with them to reach a consensus on key principles. It has taken quite a bit of time to do that, so there are some lessons to be learnt from that in terms of how we can get some engagement on that.

[132] On stakeholder input, again, it is about making sure that you hear the voices of those people who do not want to speak up. Looking at our consultation evidence—and this fits across the UK—probably only about 5% of the population does engage. So, where is the other 95%? Why are those people not engaging? It is because some people do not want to or because they feel that it does not involve them. So, how we get to hear the voice of the silent majority is an issue on which we could all spend a bit of time learning from each other.

[133] Those are just a couple of the points that I have noted with regard to lessons to be shared and learnt. Of course, we are doing that with the south Wales programme; we have all been sharing with each other in terms of some of the themes that are coming through, on how you engage, rights and responsibilities, information sharing and, again, how you get to those people who may not want to engage.

[134] **Mr Lang:** The only comment I would add is that the exercise that we have just been through—as well as that which Hywel Dda is involved in and that which south Wales is about to go through—is the first major test of the consultation and engagement guidance that the NHS in Wales is working to. There is an opportunity to reflect. The Assembly committee has been looking at this. There will be lessons learned in terms of expectations and people's perception of what constitutes good and ready engagement, and, as an NHS in Wales, we need to reflect on that. We have some very practical issues in north Wales to reflect on, but there is an opportunity for the NHS in Wales to look at that guidance to reflect on experience, to be more specific in some areas, and perhaps less so in other areas. However, NHS Wales has an opportunity, probably next year, to learn some lessons from what will have been a minimum of three very substantial engagement exercises.

[135] **Darren Millar:** I am afraid that the clock has beaten us, so we will have to call it a day with you. Thank you very much for joining us via tv over the internet. It has been good to see you this morning. I am sure that you will take a keen interest in our report when we produce it. Thank you very much for the evidence; it has been very helpful.

[136] Just as a note to Members, we will not be going into private session at the end of this meeting. We will just concentrate on taking evidence from the health boards this morning. We will take item 6 as a paper to note in terms of our forward work programme, and we will have some discussion via other forms of communication about the River Lodge key issues paper. That is just to reassure you all that we will not be here until midnight.

[137] We will now move on to take some evidence from Cardiff and Vale University Local Health Board. I am pleased to welcome to the table Adam Cairns, chief executive, and Kevin Orford, the interim financial director of the health board. Welcome to you both. I do not know

whether you wish to make a few opening remarks before we move to questioners proper, but I would like to give you the opportunity to do so. It is over to you, Adam.

[138] **Mr Cairns:** Thank you very much and good morning, everyone. Five months in to my life in Wales, I am very much enjoying working in Wales. Kevin has been with us for four months as interim director of finance. First, I just want to be clear that we understand that we are running a very important healthcare organisation. It is about patient care and patient services, and I want to reassure the committee that, despite the substantial financial pressures that we are under, safety and quality are things that we are very mindful of and are very focused on.

[139] Thinking about our approach to today, we feel that it is important that we are open and straightforward with you—I hope that you can see that in our board reports. We are clear that we need to operate with the appropriate level of transparency. In terms of context, it is important to recognise that the Cardiff and Vale University Local Health Board only met its financial duties last year, as you know, with £12 million of brokerage, all of which was backed by recurring expenditure, and £16 million of non-recurring measures in that position, with the requirement to pay back £6 million of that non-recurring brokerage this year. It is worth noting that because it is part of the challenge that we face, and it is to do with our focus on financial year ends rather than our underlying financial position.

[140] For the current year, we have an enormous challenge on our hands. We have a review of our position that the Wales Audit Office has delivered to us through our annual audit letter, which is on our website, and it is rightly critical of the position in which we find ourselves. When we got to the bottom of our position in September, we were clear that we were facing an unplanned and unfilled gap, if you like, in our budget of £37.5 million halfway through the year.

[141] I have a couple of further comments to make. The Welsh healthcare system is really a closed system. The reason why I make that point is that we are not going to solve these problems by cutting services. When we cut a service, the patient's need does not go away and that patient will reappear elsewhere in the system. So, cutting services simply will not give us the financial returns that we all need. However, we can change our way out of this difficulty. Our focus is very much on changing the way that our services are designed and delivered. The important point to note about that is that it means that we have to take people with us—the patients themselves and, really importantly, the clinicians who, in the end, have to be responsible for designing and delivering new ways of offering our services. We have a lot of potential to do that and we are very focused on securing those sorts of changes for the future and building a much more sustainable financial platform for all of our services.

[142] **Darren Millar:** Thank you for those opening remarks. You said that the figure now is around £37.5 million in terms of your worst-case scenario for the end of the year, and that includes the £6 million that you have to repay in terms of the brokerage.

10.15 a.m.

[143] **Mr Cairns:** Yes, it is.

[144] **Darren Millar:** I just wanted to confirm that. You indicated in your opening remarks that you want to manage a way out of the current financial situation through change in the organisation. I know that in south Wales there is collaboration across a number of health boards in order to deliver the sorts of service change that you feel might be necessary to meet that financial challenge. We have just heard from Betsi Cadwaladr LHB that its service change proposals will save it only £20,000 a year. How much are your service change proposals at the moment likely to save you? It will not meet the challenge.

[145] **Mr Cairns:** I will make a distinction with what we referred to with the south Wales programme, because, honestly, at the moment, the simple answer is that I do not know. However, I will give you an alternative example: one of the areas in which we have the most opportunity to improve is the way that we manage acutely unwell patients. We call it unscheduled care. If you were listening to the radio yesterday, you will have heard a lot of commentary about the experience of frail older people. Too many frail older people are being admitted to hospital unnecessarily. The consequence of that is that they become trapped—in using the word 'trapped', I do not mean that we hold them prisoner—they stay in hospital because it is very complex to get those people with complex needs back home again. There are different models that would enable us to diagnose more accurately and quickly the precipitating condition that that patient arrives with today, pay attention to that rapidly and return them home again quickly. That is one illustration; I could give you lots of other examples of where, if we get a more accurate, timely and senior medical perspective on what patients are presenting with, we can change the whole way in which this system is currently relying on hospital beds, for instance, as a solution.

[146] **Darren Millar:** In terms of your demographics, we have heard that demographics across Wales are ageing, but that in Cardiff and Vale, they are going into reverse. That is the information that we were provided with last week by the Welsh Government. If that is not right, perhaps you can correct it.

[147] **Mr Cairns:** Far be it from me to challenge the Welsh Government. The difficulty is in the detail. If we look at the over-75 population, we see there is a net decline in that age group, and we can imagine why that might be—people retiring to the coast and so on. However, if you look at the over-85-year-old population, and, by the way, they are the most intensive users of our hospital services, you will see that, in fact, the growth in our over-85s exceeds the Welsh rate. Between 2001 and 2011, our population over the age of 85 has gone up by 32.2% and across Wales by 27%. So, it depends on where you draw the line; that is what I am saying.

[148] You will also know that the other intensive users of healthcare services are young people—children. Our numbers since 2001 are up by 12.5%, and across Wales they are up by 6.2%. So, we have growth in the areas of our population that demand more of healthcare resources.

[149] **Julie Morgan:** When you say children, what age range is that?

[150] **Mr Cairns:** Under the age of 16.

[151] **Darren Millar:** This year is the biggest financial challenge yet in terms of the context and there is a bigger impact on finances here than in any other part of the UK. You have experience elsewhere in the UK, what sort of changes are you seeing in Wales that might be different in terms of the approach taken to this financial challenge?

[152] **Mr Cairns:** I was pleased to hear that a discussion is now taking place, to some extent shaped by this committee, looking at the financial regime in Wales. One of the ways in which our financial regime is not producing the right kinds of behaviour is this focus on one year and a year-end balance, because people are then inclined to focus simply on getting to that finishing line, each and every year. If you go back to look at last year, you can see that lots of non-recurring measures were put in place to get there, but the underlying recurring position was not addressed by those non-recurring measures. A much better model would be to look at a two or three-year time frame and pay attention not to the end-of-year results, but to the underlying recurring position. When running any kind of successful organisation, you have to be able to make ends meet recurrently, and that would be a significant enhancement to

the way in which we go about our business in Wales, if that was where we ended up.

[153] **Darren Millar:** I will just ask one final question before I call Gwyn. The situation is such that the more information you have, the easier it is for you to plan ahead as health boards. What sort of indications have you had from the Welsh Government about your finances beyond the next 12 months and into 2014-15 et cetera?

[154] **Mr Cairns:** We are making assumptions, which I think are prudent, based on the environment in which we are operating. If we were planning on the basis of a 4%-5% cost-reduction requirement over the course of the next three years, that would be perfectly reasonable.

[155] **Darren Millar:** That is what you are planning ahead with on the current basis. Is that consistent across Wales? Is that what everybody is working to?

[156] **Mr Cairns:** Pretty much so, yes.

[157] **Gwyn R. Price:** Good morning. What were the main causes behind the health board requiring £17 million extra funding and £12 million brokerage last year? What action have you taken to address these points?

[158] **Mr Cairns:** I will start, and Kevin might want to add some detail. The truth is that it is really in the shape of last year's expenditure. First of all, the situation is very complex—a plan gets laid, then events occur, you can go up and down, and risks happen and so on. During the course of last year—it is difficult for me to talk with any precision, because I was not here—my working assumption would be that there was a plan, and that plan had a significant amount of non-recurring elements to it. In my experience, when you are attempting to eke out non-recurring measures, that can be quite tricky, but recurring measures take time to implement. My suspicion would be that time elapsed versus money required to be saved were not quite in synch.

[159] **Gwyn R. Price:** What have you done to address that?

[160] **Mr Cairns:** The first and most important requirement that Kevin and I have had is for us to understand our position, and get to the bottom of where we are. We have done that. We know where we are, we understand the position that we are in, and what we are now doing is thinking ahead and planning for the future on the basis that we are determined—absolutely determined—to get back into a full, recurring, balanced position. It will take a bit of time to get there. I mentioned in my introductory remarks that it is really important that this is not something that the director of finance or the chief executive can do; we have to get our clinicians, in particular, with us. They have to own the fact that our circumstances are such that we have to redesign how we deliver care. To give you a specific example, we have very powerful clinical engagement building, and we have agreed that we will make some rapid changes in how we manage our unscheduled care activities before Christmas this year. That will improve the patient experience and improve quality, but it will also lower cost.

[161] **Gwyn R. Price:** You have three weeks to do it, then.

[162] **Mr Cairns:** We have been talking about it for about six weeks, and my point is that we need to get a move on. There is clear evidence from other parts of the UK and across the world that, if we organise ourselves differently and bring more senior doctors into the care delivery system earlier, and if those clinicians target treatment more effectively, we can move patients through our system appropriately and more quickly. No-one wants to be in hospital any longer than they need to be. If we can get them safely back home, not having had a prolonged hospital stay, that has to be good for the taxpayer, the patient and the organisation

that we run. It is about getting our clinicians to buy into the leadership responsibility that they have to demonstrate in taking these challenges forward. That is what we are working on.

[163] **Mr Orford:** In terms of our historic financial planning processes, the Wales Audit Office identifies in the annual audit report that we need to make some improvements. What we have done over the last two to three months is kick off an exercise to benchmark everything that we do in terms of quality and finance with the upper quartile across the whole of the UK. In the next week or so we will have that analysis, and that will give us the start of a conversation with each of our clinical areas on how we can make improvements that give better patient outcomes or a better patient experience, but also provide better value. So, among the things that are in there, we are looking at benchmarking length of stay, specialty by specialty, against the upper quartile, day-case ratios and out-patient follow ups—all those things that, if you get into the upper quartile, are better for patients. They also enable you to get better value out of the resources that you employ.

[164] **Gwyn R. Price:** With that in mind, did the fact that the Welsh Government provided additional funding last year, having previously said that no further funding would be available, make it more difficult for your financial managers to emphasise the need for cost control to other members of staff?

[165] **Mr Orford:** I do not think so. I was not here last year, but since I got here in August my main message to the organisation—to all the clinical directorates—has been that we have a statutory obligation to break even. The finance function is there to help each of the budget holders to bring their finances into balance, but I do not think that there is a sense that we do not need to do it because additional money will come in. I have not sensed that since I have been here.

[166] **Darren Millar:** Let me get this right: in spite of the tough talking on the budget, the fact that the Welsh Government has put its hand in its pocket to deliver extra finance, whether through brokerage or by giving more cash from its reserves, on an annual basis for many years has not given the impression to the people whom you are working with that they should do what they can but that they will never have to meet the huge challenges ahead as they know that, in the end, they will be bailed out in some way, shape or form. There is not that sort of attitude among the people in your health board.

[167] **Mr Cairns:** If we go back to the earlier point about whether or not our goal is to be in recurring balance, the sophistication of the level of understanding that our people need has to get better. So, the history has been of a year-end balancing figure, and they watch us deliver that partly through recurring measures but also by way of lots of non-recurring items. If we are moving away from a reliance or dependence on non-recurring measures, we are getting to a place where, genuinely, we are all interested in the underlying recurring position. That, I think, is the key piece that we have to get in place. It is about owning that underlying recurring position.

[168] **Darren Millar:** What are the non-recurring measures that were taken in your health board last year? Give me a few examples.

[169] **Mr Cairns:** There would have been an attempt to reduce the number of staff recruited over a period. There would have been reductions in things like training allocations. There would have been a review of travel and subsistence costs. There would have been a whole host of items of that kind, none of which you can sustain. You have to continue to train people—you cannot not train people. You have to look very hard at how your inflow of new staff works over the full year.

[170] **Aled Roberts:** Gan dderbyn mai dim **Aled Roberts:** While I accept that you have

ond ers mis Gorffennaf ac Awst rydych wedi bod yn eich swyddi, os edrychwn ar eich cynllun ariannol ar gyfer eleni, gwelwn fod diffyg o ryw £20 miliwn rhwng eich cynllun arbedion a'r bwlch cyllido y cyfeirir ato yn adroddiad yr archwilydd cyffredinol. Mae'n rhaid inni hefyd ystyried bod £13.7 miliwn o'r arbedion yn y cynllun heb eu canfod. Felly, a oedd gan eich bwrdd iechyd chi gynllun ariannol llawn ar gyfer eleni ar unrhyw adeg?

only been in post since July and August, if we look at your financial plan for this year, we see that there is a gap of some £20 million between your savings plan and the funding gap identified in the auditor general's report. We must also consider that some £13.7 million of the savings in the plan are yet to be identified. Therefore, did your health board, at any time, have a full financial plan for this year?

[171] **Mr Cairns:** The easiest thing for me to do is simply to say 'no'. The Welsh Audit Office letter that we have received—we have an annual audit letter—says that the budget-setting process was delayed, protracted and failed to identify sufficient cost reductions to deliver a balanced budget. The budget did not have adequate links between workforce capacity and service planning. Required cost reductions were not being achieved, and some of the cost reductions were unrealistic, aspirational and not clearly linked to service delivery or workforce and capacity plans. That is what the audit office said about the budget-setting process for last year. There was a discontinuity of leadership in the health board. I am not walking away from the responsibilities that I have, and we are working really hard to repair that position now.

10.30 a.m.

[172] **Aled Roberts:** Erbyn pryd y byddwch yn canfod yr £13.7 miliwn?

Aled Roberts: By when will you have identified that £13.7 million?

[173] **Mr Cairns:** It is an ongoing task, because we have lots of work to do to close that gap. If we look at where we are at the moment, I do not think that we have not closed that gap at all. We have not closed that gap completely, but it is a piece of work that we have to continue working on for the rest of this financial year. There are risks in our position currently, which we have identified, I think, very openly in the way in which we have been reporting our position. We have also been flagging those risks consistently with the Welsh Government.

[174] **Aled Roberts:** Yn ystod y flwyddyn, pa drafodaethau yr ydych chi wedi eu cael gyda Llywodraeth Cymru ynglŷn â'r posibilrwydd o gael arian ychwanegol i'ch cronfeydd chi o gronfeydd y Llywodraeth?

Aled Roberts: During the year, what discussions have you had with the Welsh Government regarding the possibility of having additional money for your funds from Government funds?

[175] **Mr Cairns:** Our responsibility, first and foremost, is to understand and then own the financial circumstances of our organisation. I arrived in July and there was no finance director. We had a finance director in August and we worked through that during August. By the time we got to September, it was clear where we were. We have been consistently straightforward and open about the situation in which we find ourselves, but, at the same time, we have committed ourselves absolutely to doing everything that we can to manage this position.

[176] **Aled Roberts:** Last week, Mr Sissling identified that he would be willing to use contingency funds to provide additional funds. Have you had any specific discussions with the Welsh Government regarding additional funds to your health board?

[177] **Mr Cairns:** We are now aware—and I think that it is very helpful to note—that there

has been a mid-year review, and we understand that Mr Sissling has retained a contingency. That sounds like very prudent and sensible management to me. We are hopeful that we will have some support for some of the gap that we are currently struggling to close.

[178] **Aled Roberts:** You have had no discussions up to now, have you?

[179] **Mr Cairns:** We have had some conversations about the extent, the size, the dimensions of our problem, our pace of recovery, our forecasts and so on. That is the kind of conversation that we have been having.

[180] **Aled Roberts:** Last year, apart from, I think, two health boards, each health board was given the same sum, even though we were told last week that a sophisticated analysis had been undertaken of the requirements of each health board and its demographic challenges. What understanding do you have of such sophisticated analysis being undertaken this year?

[181] **Mr Cairns:** I honestly do not know, because I just do not know what the Welsh Government team has been doing in that department. I know what we have been doing, and I can confirm that our analysis is sufficiently sophisticated and detailed for us, together, to understand in detail the position that we are in. We are certainly in a place to share that level of complexity and sophistication.

[182] **Darren Millar:** It is interesting; the contingency fund, as the committee understands it, is £50 million, but if we take the two upper figures that you have given us today and which Betsi Cadwaladr University Local Health Board has given us today, it takes us to £61.5 million for just your two local health boards. So, the scale of the challenge is pretty significant.

[183] **Jenny Rathbone:** Looking at the scale of the challenge, and looking at the auditor general's update report, I see that there is one particular targeted saving where there has been a dramatic failure to meet your target of £20 million—you have achieved £5 million. Why has that not gone according to plan? I am talking here about procurement and other non-pay savings.

[184] **Mr Orford:** Adam referred earlier to the financial planning process for this year and the gap in the budget; that gap was allocated into non-pay budgets. So, if you look at the rest of our budgets, for example, on pay, we are on track with that and we are on track to meet the cost improvement programmes that were agreed with budget holders at the start, but all of the gap went into non-pay. So, our challenge is in that area.

[185] **Jenny Rathbone:** Will you achieve the £20 million savings, or is that totally unrealistic?

[186] **Mr Orford:** We will not achieve it in non-pay savings. I do not think that that was a realistic expectation, as the budgets were set earlier in the year. We are trying to tackle that by driving non-pay savings further, around procurement and medicines management. We are also looking at further pay savings to try to offset that, so we have set some expectations around the levels of variable pay in relation to agency bank staff between now and the end of the year. We are hoping that that will deliver about £4.5 million in savings, which will go towards the gap to which you referred. We are unlikely to fill the whole gap at this stage.

[187] **Mr Cairns:** I would like to come in on this point. The unallocated budget gap was put into non-pay budgets as negative expenditure, but without a plan to deliver it.

[188] **Jenny Rathbone:** So, it was just a work of fiction, basically.

[189] **Mr Cairns:** I would not say that. However, the budget gap was certainly put in there as negative expenditure without a plan. That was where the gap sat. Given that there was no plan initially, we have been working very hard to turn that gap into deliverable and achievable plans across the year, as far as we can.

[190] **Jenny Rathbone:** You spoke earlier about the particular demographic pressures that you are facing, and the elderly population is one. I am surprised that you are an outlier in terms of the increase in the number of children using your services. Could you explain why that is?

[191] **Mr Cairns:** The age structure of our population demonstrates that we have a rising birth rate, which is higher than in the rest of Wales. We have a younger shape to our population, so there are more people of child-bearing age. Given that that is the case, and that we are also seeing net population growth, those factors combine to demonstrate that we have more children. From a service delivery perspective, we are also providing a range of specialist services for children to other health boards. So, the proportion of children accessing our services is already shaped to a significant extent by the fact that the population of Cardiff and the Vale has more children in it than that in the rest of Wales, and, also, from a service delivery point of view, we are seeing very complex and difficult-to-manage children coming, appropriately, to Cardiff to have their specialist treatment.

[192] **Jenny Rathbone:** You said earlier that there was a need to get senior clinicians to assess problems more quickly, so that the correct treatment is put in place and people get out of hospital more quickly. What is being done to reshape the treatment that we provide to people with diabetes? At the moment, 80% of diabetes spend is on doing things in secondary care that might have been prevented in primary care.

[193] **Mr Cairns:** Diabetes is an enormously important disease process. The consequences of poorly controlled diabetes are extremely damaging to individuals and, when aggregated, are extremely powerful drivers of cost in the health service. As a board, we have been thinking about which groups of our population we need to focus on the most in the future to improve health outcomes and, in so doing, to help us to manage the burden of healthcare costs. The board has not finalised the decision on this yet, but we are making a strong case for the board to agree that two groups of our population will be particular areas of focus for us. One of those is diabetics. We want to examine the potential, working with partners, to go upstream to look at the factors that are driving the obesity epidemic that we have on our hands, and obesity is a very important factor for type 2 diabetes. We also want to look very hard at how good a job we are doing as medical professionals, in working with our patients, to help them to control their diabetes more effectively. Over the next three years, we have big plans to significantly enhance the way in which we are managing diabetes and helping people to manage it themselves.

[194] **Jenny Rathbone:** In your category of senior clinicians, I would include GPs. They clearly have a key role in ensuring that people are getting the primary care service that they need that prevents them from ending up in hospital.

[195] **Mr Cairns:** That is true, and the GPs to whom I have spoken all recognise that they have a key role to play. I am also really keen for us to find ways of reaching patients and helping to support them. In a year of their life, they are in front of a healthcare professional very infrequently. So, we need to be equipping patients, people who have diabetes, far more effectively than we are currently able to do, so that they are in a better position to manage the things that will influence their own outcomes—and, indeed, the complications, which are avoidable, that they will incur if we do not equip them.

[196] **Jenny Rathbone:** Looking slightly further ahead, how confident are you that the

measures that you are putting in place to get people seen quicker and more appropriately will deliver the financial break-even that you will need to meet in the following financial year?

[197] **Mr Cairns:** Care delivery systems are very complex, particularly things like unscheduled care. There is the pre-hospital environment for people with long-term conditions, in how they interact with their GPs and manage their own conditions; their early precipitating signs; the immediate assessment phase when they arrive at a hospital; the immediate post-admission phase; the in-hospital phase; and then the transfer-out phase. So, we must have a plan to get all that delivering more effectively for patients. We are starting with the narrow slice, which is looking at what we can do better when patients present to hospital and need to be assessed, and how we can manage the first 72 hours of their admission and stay in hospital. That is what we are focusing on now. We need to unroll a plan for the rest of unscheduled care. It will take time for us to do that, but there are big dividends for patients and for us as an organisation—quality, outcomes and also cost—if we can get all that working together.

[198] Unscheduled care, if it is not working well, has a distorting effect on lots of the other things that are important to patients and to us, having an impact on cost and quality. For instance, if a patient is outlying—we call it 'outlying' if a patient is in the wrong bed—it might mean that a surgical case that needs to come in cannot get in. We then have to put on additional activity at weekends or in the evenings to get that patient treated. You can imagine the cost that we incur in doing that. So, it is far better for us to get to the root cause and fix it. There are all sorts of spin-offs that we could obtain if we got that working much better than it is at the moment. It is not the only thing that we will be doing, but it is important.

[199] **Jenny Rathbone:** Okay. So, you think that that analysis of the first 72 hours of unscheduled care is going to deliver a steady state, financially.

[200] **Mr Cairns:** No, not on its own. It will be an important contributing factor, but there will be lots more that we have to do. I am simply giving that as an example of a clinical service redesign that we need to do.

[201] **Darren Millar:** Aled, you are next. Could you be brief on this, please, and could you also keep your answer as brief as possible?

[202] **Aled Roberts:** Yes. You told us this morning that the savings target was not realistic and was not supported by a plan. So, could you help me with the level of challenge, which is governed by the Welsh Government, of financial plans that are sent in by the health boards? Could you also indicate how robust you think your profiling is, given that, in the auditor general's report, you report your most likely position as also being your best case? You were not the only health board to do it, but we have some concerns regarding that scenario, as well.

[203] **Mr Cairns:** I will ask Kevin to pick up on your second point. On the first point about the Welsh Government, I have not experienced a cycle of sending in a budget and seeing what happens, so I cannot really comment on that. All I can say is that, since our arrival, we have had appropriate, robust, challenging conversations about our position. Our end of that is to be really clear about where we are and to be straightforward about what we think our position is.

[204] **Aled Roberts:** What was its attitude to your coming in and finding that the savings target was not realistic and was not supported by any plans?

[205] **Mr Cairns:** Get on and sort it—quite appropriate.

[206] **Aled Roberts:** And on my second point, on profiling—

[207] **Mr Orford:** Profiling is probably not the real issue at Cardiff and Vale health board.

Where we have plans—for example, we have £36.7 million of cost-saving plans that were agreed at the start of the budget-setting process—they are largely on track at the moment and are profiled appropriately throughout the year. We are largely meeting those targets. Equally, on the pay budgets, we have very little variance on the pay, so that is also working. The problem that we keep referring back to is the gap, which you cannot profile in any scientific way, so that is profiled in twelfths over the year. However, the profiling is not the issue; the issue is not having the detailed plans to support the gap, which is what we need to put right for next year.

10.45 a.m.

[208] **Aled Roberts:** Where you are at the moment, is your most likely outcome your best case?

[209] **Mr Orford:** The figures that you are quoting are, I think, the ones that we were quoting in September. I think that it would be unlikely that we would have a deficit of only £20 million at this point. To do that, we would need to reduce expenditure by £2.5 million each month from now until the end of the year. That looks very challenging in the winter period. As we submit the next set of numbers for the end of November, which we will be submitting at the end of this week, we will be revising those best and worst-case numbers.

[210] **Darren Millar:** To what?

[211] **Mr Orford:** I do not have the end of November figures yet, so I would not like to put a number on that at this point, but within the next three days we will have that.

[212] **Darren Millar:** You indicated at the start that around £37.5 million is more realistic as a worst-case scenario.

[213] **Mr Orford:** I do not think that that is the likely case.

[214] **Darren Millar:** That is the worst case, is it not?

[215] **Mr Orford:** If you take the Wales Audit Office trajectory, which is to take the trend of expenditure from now until the end of the year, you would come up with a figure of around £35 million, but the actions that we have put in place will mean that we are going to come in with a figure lower than that. However, as we sit here today, knowing the risks that we are facing and looking ahead to winter, I think that the £20 million best-case scenario probably comes to something like £25 million to £27 million.

[216] **Darren Millar:** Okay. Thank you for that.

[217] **Mike Hedges:** I have two questions, both very brief. First, how important are social services and social care to your meeting your plan? The second is on procurement. What are you doing, working with either local authorities or other health boards, to reduce procurement costs? One of the problems that exists in organisations where they have different budget heads and different people ordering things is that you can over-order for the organisation while ordering the right amount for one part of the organisation. I used to work in a college where that happened with printer cartridges. Every department ordered a spare printer cartridge, when the reality was that the college probably needed only four spare printer cartridges at any one time, because they dry out et cetera. However, we ended up with 20 printer cartridges, because every department had to look after itself. Is anything being done to deal with that type of problem?

[218] **Mr Cairns:** Kevin will pick up your second point. On your first point, the

relationship with social care is extremely important. I am pleased to say that there is a very good feel to that relationship locally in Cardiff and the Vale. We work collectively and cohesively as a top team. There is lots of good collaboration on the ground, there is goodwill, and people understand that there are things that we can do together to influence the experience of patients and citizens. So, I think that there are prospects for good progress in that area in Cardiff and the Vale.

[219] **Mr Orford:** Procurement savings are an important part of our financial plan. This year, we are estimating that we will make £7.2 million-worth of savings on procurement. The points that you are raising about getting further efficiencies are our next big challenge. Cardiff and the Vale is a large health board: we spend £1.1 billion a year. A significant amount of that is procured—non-pay—so we have some very active work under way at the moment to look at how we can rationalise some of our procurement decisions and the kind of things that you are referring to. That will be building into next year's plan.

[220] **Mike Hedges:** What about working with others?

[221] **Mr Orford:** I know that there are some all-Wales contracts that we operate within, although I am not close to those. Part of our plan is to take good practice from the rest of Wales and build it into our own procurement plan.

[222] **Mike Hedges:** What about working with local authorities or consortia of local authorities on buying consumables such as photocopier paper? I am sure you that you go through hundreds of thousands of pounds-worth a year.

[223] **Mr Orford:** I am not aware of any joint procurement with local authorities, but I can look into that and let you know of any examples, if we do have some.

[224] **Mike Hedges:** Can you examine it?

[225] **Mr Orford:** Indeed, we will.

[226] **Julie Morgan:** Before I go on to ask you about staffing levels, I want to ask you about the position of being a specialist centre, with people coming to you from all over Wales. Do you feel that that is recognised financially in the settlement that you get? Are there any difficulties in getting the right payment for some of the treatment that patients receive?

[227] **Mr Cairns:** Financial formulae are complex. When I do some simple calculations—this is unweighted, so it almost certainly will not tell us very much—per head of population we receive £1,611. That is the lowest figure per head of population in Wales. I imagine that the review of the financial regime will look at those kinds of funding formulae and assess whether they are right. It is a very complex area.

[228] In terms of the services we offer to Wales, one of the things that we will be doing is examining the costs that we incur as a health board in delivering those services, comparing that to the income that we receive from outside the health board, because one of the risks for our local population is that we subsidise all-Wales services at the cost of our local-population services. We need to be clear whether that is happening. I cannot tell you, sitting here today, whether that is the case, but we are looking at that very carefully.

[229] **Julie Morgan:** I have worked quite closely with haemophilia patients, and there is a centre of excellence at the Heath hospital, and people come from England to visit it, which is absolutely fantastic. However, in terms of the drugs that are then dispensed, that seems to depend on the authorities that send the patients, and there has been a dispute about that. I wonder whether that happens often. Maybe that is too detailed to go into now, but I just

wondered whether that is an example of where additional financial problems come in.

[230] **Mr Cairns:** Part of our challenge is that we are stuffed to the gunnels with really bright doctors and surgeons who have inquiring minds and who develop new services. Yesterday, I was talking to some doctors who have now worked out how to mechanically retrieve a clot from inside your brain. You then get off the table and you walk home, having had a stroke. There are enormous challenges about how we handle the technology wave and how we ensure that services that are developed have a sound financial footing, backed by an all-Wales approach.

[231] **Julie Morgan:** Thank you for that. How realistic are your plans to increase staffing levels this year, given the financial position?

[232] **Mr Orford:** Management and recruitment between now and the end of the year will be quite important in terms of managing the finances. The latest numbers that I have in terms of our projections for staff at the end of the year will be that we will have a reduction. We will have 12,336 whole-time equivalent staff at the end of March, and that will be a reduction of 115 on the previous March. That reduction of 115 is not enough to manage the financial position in the way that we want to between now and the end of the year, so we are looking for further recruitment, management and vacancy control between now and the end of the year to do that. So, that reduction may well increase between now and the end of the year.

[233] **Julie Morgan:** So, will you achieve your aim of having £5.2 million of savings by reducing the staffing establishment?

[234] **Mr Orford:** The £5.2 million of savings is part of the plan at the start of the year, as part of our cost improvement plans that were agreed. That is all on track. Lots of that £5.2 million of savings from workforce numbers is coming from actions that were taken at the end of the last financial year. We had a voluntary exit scheme for staff. So, staff numbers reduced in the final four months of last year. We have not recruited into those vacant posts. So, that £5.2 million is a benefit for this year's plans. So, that was action that was taken at the end of the last financial year.

[235] **Julie Morgan:** What about quality of patient care with the financial restrictions that you have to work with? Are there any areas where you can say that you feel that patient care has suffered?

[236] **Mr Cairns:** I think that our attitude, increasingly, has to be that we need to improve what we do. We need to be able to see improvements in quality and safety. We measure this very carefully. We have lots of information at our board meetings about our quality and safety risks. In my experience, there was an enormous convergence in designing good care with good economics. So, as long as that is our approach, we will be fine.

[237] **Julie Morgan:** Looking at the last six months, are there any areas where you feel that the quality of care has not been as it should be?

[238] **Mr Cairns:** I am sure that there are. I have mentioned already, a number of times, the unscheduled care system. I am not happy that that unscheduled care system is working in every respect as it should. We have lots that we can do to improve that and, as we improve, we will find that it costs us less as well.

[239] **Julie Morgan:** So, you think that unscheduled care is the main area?

[240] **Mr Cairns:** I think that that is where I have most concern.

[241] **Jocelyn Davies:** I want to ask you about the reconfiguration plans. How are they progressing? Will the changes be financially sustainable, and can you say a little about the costs?

[242] **Mr Cairns:** The situation is that we are in the engagement phase, as you know, so we are simply laying out the circumstances and why we think that change is necessary. We are having conversations outside and inside of Cardiff and Vale LHB. The issue that we have in modelling through the financial consequences is that it will significantly depend on what the final proposal looks like in the end. There is an almost infinite number of potential permutations, so, at the moment, I cannot tell you what the financial consequences of that will be.

[243] As we get closer to the point where we are hopefully consulting on a preferred model, we will be able to say what we expect the financial consequences of that to be, and we will have worked that through in the necessary detail at that time.

[244] **Jocelyn Davies:** I listened to what you said about unscheduled hospital stays—old people coming in with water infections, thereby making it difficult to go back home; and children coming into hospital with broken bones or to have their appendix out—some kids go to hospital pretty regularly as a result of accidents and so on. If you changed to a different way of delivering services, are you going to run dual services or are you just going to switch over? What will your attitude be towards risk? Will you rely on someone else to deliver services on your behalf, such as the local authority or the voluntary sector?

[245] **Mr Cairns:** No. At the moment, our focus is very much on looking critically at what the evidence base tells us that great care looks like, comparing what we do with that evidence base and inviting the clinical teams to sit down and work through ways in which we could get closer to where the evidence tells us we should be. I have to require the clinicians, in a sense, to lead that conversation, because they have to make and own that change.

[246] I think that that is going pretty well. We have strong engagement from our clinical teams, and last night we were in a room and heard how a lot of self-starting improvement is beginning to happen from the bottom up, which was really good to know. So, there is plenty of hope, but we have to almost industrialise that process of improvement across the organisation. That is what I need to make sure we do.

[247] **Jocelyn Davies:** We had recent evidence about Cardiff and the Vale LHB having a new project about stopping older people coming into hospital, with invest-to-save money from the Welsh Government. Will that rely on delivery of services by the local authority?

[248] **Mr Cairns:** It is a collective effort. We call it the Wyn campaign. There is an invest-to-save scheme. We are at the early stages of implementing some new designs, but it is based on meeting the older person's needs, whether they are health or social, in ways which best support increasing independence. That is in social care's interests and in ours, as well as, more importantly than anything else, the patients' interest. That scheme is off the blocks, it is starting to move forward and we can develop much more of that type of design.

[249] **Jocelyn Davies:** However, you will probably still be running services in parallel. I appreciate that you have not been in this job for a long time, but do you know if you fund any services through the voluntary sector and the local authority?

[250] **Mr Cairns:** Yes, we do.

[251] **Jocelyn Davies:** Could you send us a note on that?

[252] **Mr Cairns:** Yes, we will.

[253] **Darren Millar:** Thank you for that. The final question is from Oscar.

[254] **Mohammad Asghar:** How are you addressing the problems that have hampered NHS reform in the past, such as involving the public, clinicians and other key local stakeholders in decision making? What resistance and criticism have you received from your staff and what is your approach for getting politicians on board to get the job done properly?

[255] **Mr Cairns:** I can caricature this: if we were to say to people, 'We want to save money by closing hospital beds—how about it?' you will not get very many people stepping forward saying, 'How can I help?'. If you say to people, 'The evidence tells us that we could deliver better outcomes, more patients would survive our care and they would get home in a better condition—how about that?', then we would then get people involved in the conversation. The end result is that we will probably need fewer hospital beds, but you have changed the terms of reference for the question. So long as that is where we are coming from, we will get people participating, as we need them to, in working through how we make all those things happen.

11.00 a.m.

[256] **Mohammad Asghar:** What about the political will behind it?

[257] **Mr Cairns:** We have to give politicians a chance. If we say to politicians, 'We'd like you to get behind closing a load of hospital beds'—and that is all we say to them—do not be surprised if politicians find that rather difficult. If, instead, we say, 'This is clinically led, it's based on sound evidence, patients will benefit and have been involved in the design process, so will you help us?', we are in a different place.

[258] **Darren Millar:** Thank you very much for that useful evidence, which certainly helped to inform the report that we will publish at the end of this piece of work. Thank you, Adam and Kevin, for your attendance today. If there is any further information that you want to send us, in addition to the information that you discussed with Jocelyn Davies, we would appreciate that.

[259] We now bring our meeting to a close. Thank you.

Daeth y cyfarfod i ben am 11.01 a.m.
The meeting ended at 11.01 a.m.