Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

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Tuesday, 5 November 2013

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Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

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
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Adam Cairns	Prif Weithredwr, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Chief Executive, Cardiff and Vale University Health Board
Kevin Flynn	Dirprwy Brif Weithredwr GIG Cymru Deputy Chief Executive NHS Wales
Mark Jeffs	Swyddfa Archwilio Cymru Wales Audit Office
David Sissling	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol/Prif Weithredwr, GIG Cymru Director General for Health and Social Services/Chief Executive, NHS Wales
Martin Sollis	Cyfarwyddwr Cyllid, Llywodraeth Cymru Director of Finance, Welsh Government
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

Fay Buckle	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Meriel Singleton	Ail Glerc Second Clerk

Dechreuodd y cyfarfod am 09:00.
The meeting began at 09:00.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody, and welcome to today's meeting of the Public Accounts Committee. I remind Members and witnesses that the National Assembly for Wales is a bilingual institution and there are headsets available for translation for those who require them. I encourage Members and witnesses to turn off their mobile phones, Blackberrys and pagers because they can interfere with the broadcasting and other equipment. I just want to remind everybody as well that there is no need to push the buttons on the microphones. They all will be operated automatically. We have not received any apologies for absence today, so we will go straight to the next item on our agenda.

09:01

Cyllid Iechyd 2012-13 a Thu Hwnt: Tystiolaeth gan Lywodraeth Cymru
Health Finances 2012-13 and Beyond: Evidence from the Welsh Government

[2] **Darren Millar:** I am very pleased to welcome the director general of health and social services, David Sissling, before the committee today, along with Kevin Flynn, the deputy chief executive of the NHS in Wales, and Martin Sollis, director of finance at the Welsh Government. Welcome to you all. We have a number of questions that we want to put to you as a committee, but I do not know whether you want to make any opening remarks, Mr Sissling.

[3] **Mr Sissling:** No, we thought we would go straight into questions, Chair, thank you.

[4] **Darren Millar:** Super. Mr Sissling, the report sets out pretty starkly that there has been a big challenge for the NHS in Wales in recent years in terms of the finances that have been available to it. The Minister announced some extra resources for the NHS in the current financial year and a package for future years in order to support the NHS and make its finances more sustainable. Do you want to tell us a little bit about that £150 million for the current financial year and how it was calculated, because it is somewhat less than the financial gap that was identified by the auditor general?

[5] **Mr Sissling:** Yes, absolutely. Perhaps I could also cover for the committee the actions that we have taken since the Minister made the announcement some three weeks ago in terms of the statement he made. The position, you are right, is of an NHS that has made progress in many areas, but has done so in a constrained financial environment, and an environment that we know will continue to be constrained for years ahead. We have managed to bring the NHS in—the NHS organisations as a whole delivered breakeven as a whole over the last two years. In planning for this year, it was clear that we had to acknowledge some of the pressures associated with the increasing emphasis on quality and safety, and I think that I have outlined some of those in my evidence paper. The health board trust plans were ones that we said had to be absolutely clear about their obligations to provide safe care and compassionate care. They developed their plans and, as you will be aware, they were not balanced fully. There was some variation in that. Our assessment, which was based on a very rigorous, forensic analysis of the plans, was that simply to bear down on the plans at that point would have been inappropriate. The consequential ministerial action between the Minister for Health and Social Services and the Minister for Finance to undertake an overview of the implications in terms of budgets over the summer months culminated in the ministerial decision taken to provide and allocate the NHS bodies in Wales with an additional £150 million. That was an assessment made of an appropriate amount to recognise the pressures associated with quality and safety. Clearly, it requires—this is what I will go on to talk about, which is the next phase of it—some understanding of the additional stretch, in a

sense, that the health boards and trusts will have to make individually and collectively to allow an appropriate outturn to this year's financial position.

[6] Since the ministerial statements on 8 October and 17 October a number of actions have taken place, because, clearly, we need to act with urgency. The three of us have met the chairs and chief executives of all the health organisations. Kevin and Martin have met individually with each health board and trust to go through their particular positions. We are setting up national bodies. I am chairing a body with chairs, chief executives, and directors of finance. It is a small group to look at opportunities to work in perhaps a more effective way collectively, to bring best practice to bear, and to look at some of the opportunities that will be realised on a national basis only with the NHS working in a very dedicated way together. We have asked each health organisation to further develop their savings plans to allow the health boards and trusts to make returns to us over the next couple of weeks. They will be providing us with plans that show how they can accommodate the pressures within their financial means, taking account of their share of the additional £150 million. So, it is an active planning process and it continues. We will be getting in the very near future—next week—the forecast based on the month 7 performance. In that, for the first time, the health boards will have had a chance to reflect on their allocations within the £150 million and will bring to bear the additional work that we have asked them to do in terms of stretch savings where it is appropriate to do so. Clearly, some health boards are in a different position to others. In some cases, we want health boards to perhaps move into a position of surplus so that there can be some overall contribution to an appropriate year-end settlement across the NHS.

[7] **Darren Millar:** Just to be clear for the committee, the £150 million was not designed to meet the financial gap that was identified in the auditor general's report, which, of course, was much greater than £150 million. It was about £211 million, I think, at the time that the auditor general's report was published, although it has come down a little, I think, since then. It was designed to deal with other pressures.

[8] **Mr Sissling:** No. The pressures that the £150 million recognised are a sub-set of the £200 million. So, the plans that the health boards and trusts produced were very much ones that said, 'Build into your plans what you need to do to respond to and reflect on understanding the mid Staffordshire situation'. It is not just about mid Staffordshire; it is our own distinctive Welsh understanding of what high-quality care means.

[9] **Darren Millar:** Just to get this right, because I am still not clear from what you say, you are suggesting that the £150 million was a contribution to closing this gap that was identified by the auditor general. One health board in particular has had more money than the auditor general said was necessary in order to meet the financial gap that it had. The Minister, when he made the announcement about the £150 million, said that this was all about unscheduled care and dealing with risks that he had identified as a result of the Francis report. So, what is it? Is it there to meet the gap? Clearly, it is not, because it exceeds the gap for one health board, at least, and falls short of the gap for a number of other health boards. So, is it designed to meet unscheduled care pressures—risk pressures that have been identified by the Minister—or is it to meet this financial gap that has been identified by the auditor general?

[10] **Mr Sissling:** Again, just to go through it, at the beginning of the year, health boards and trusts were asked to develop plans, as I am sure that you would want us to do, that would meet their projections in terms of demand and unscheduled care pressures, appropriate planned care performance, and to develop appropriate staffing levels, for example, on their acute wards. They had to be quality assured plans. Those were the plans that they produced. So, in a sense, the elements to do with unscheduled care and other issues to do with quality and safety were an integral part of their plans. The ministerial decision to review the budgetary position—the context of that—was one, as I said, that was taken over the summer. The £150 million was the assessment of the additional funding needed within the context of

that to meet those pressures of unscheduled care, such as the nurse staffing pressures, et cetera, because nurse staffing was a very specific issue within that. The Minister took a decision within the context of a developing financial regime that the allocation should be on the basis of population shares. This very much ties into a new financial regime in which, increasingly, we want to see integrity in the allocation process, not simply a system that is pursuing relentlessly a projected deficit forecast. We want to switch the whole system so that there is integrity in the process and so that the money is allocated on a population-share basis. We have to break the pattern of the past, to be quite honest.

[11] **Darren Millar:** You wanted to come in, Mike.

[12] **Mike Hedges:** Yes. You talk about all of these budgets, but, when we listened to Betsi Cadwaladr University Local Health Board's representatives here, what they said was that they create the budget, which then goes out to the departments, which then decide whether they accept or not, and they could reject it if they so wish. So, I am not quite sure how you can do all of these clever things with these budgets when they are not even firm within the health boards. What are you doing to make sure that the health boards' budgets are firm, so that, when someone is told that they have £10 million, that is not a negotiating position for them to say, 'I would like £12 million or £13 million', but is actually what they have?

[13] **Mr Sissling:** I think that it is important, and colleagues, particularly Martin, may want to add to this in terms of the work that we are doing to enhance budgetary discipline within all organisations. I understand the direction of the question. It is clearly the case that the allocations that are provided by the Welsh Government translate into systems that have a robust, resilient, efficient and effective budgetary framework. In a sense, it is a decision to be taken at a health board or trust level in terms of the way that it is delegated and devolved to particular parts of the organisations, and there is not any sense of a perpetual process of negotiation about it; there is a point at which the particular sub-units of the organisation have to accept the reality of the situation. In some particular cases, including Betsi, the need to strengthen some of the internal financial disciplines has led to us and health boards—there are four in total—having external support to ensure that they have strength in their financial systems. I do not know whether you want to add anything to that, Martin.

[14] **Mr Sollis:** In terms of the four organisations, Cardiff has already taken support, Betsi has support in currently working with it to look at the opportunities for generating savings and efficiencies, and Powys has taken support on that basis, as has Hywel Dda. You are quite right in the sense that budgetary control is actually stipulated—it is a board requirement, and it is a requirement that they get those signed off, and that there is proper engagement on those budgets before the start of the new financial year. In terms of the Betsi reports, and the points that were raised by this committee last time around, we have shared those through the directors of finance forum, and we are looking at the report produced by the Wales Audit Office currently. We are looking to learn lessons from that to ensure that we drive those issues forward and to ensure that those budgetary control arrangements are tightened across the organisations.

[15] **Mike Hedges:** You do not need to tighten budgetary control—we just need a system in which, when someone gets allocated a budget, that is their budget. They negotiate up until the budget is agreed, but after that, that is the budget. Surely, is that not the direction that you should be telling boards?

[16] **Mr Sissling:** Yes. I agree. In my experience, good practice would be some brief period of discussion about what a reasonable budget is, but there has to be a point at which the budget is settled and the formal letters are sent out—in the way that I do with colleagues around this table and beyond. There is a point at which I write a letter formally to colleagues,

saying, 'This is the budget for the year, and it is your responsibility to live within it'. That is a very straightforward approach, and that is what we would expect at every health board, and at every trust, moreover.

[17] **Darren Millar:** I have a number of Members who want to come in; Julie is first, then Aled, Jocelyn, and Sandy.

[18] **Julie Morgan:** I am still slightly unclear about what the Chairman was asking about at the beginning, and about whether this was additional to the deficit that had been identified or not. I clearly remember the Minister for Health and Social Services, when he was presenting it, saying that this was for additional things that had not been predicted, such as unscheduled care, and he particularly mentioned four vaccines, I think, which were brought in. So, are you saying that these had already been calculated into the budgets of each health board, and that it was not therefore additional money in the sense that I had understood it?

[19] **Mr Sissling:** To an extent, yes, that was the position. Otherwise, I suppose that the other question that you come back to is whether the £200 million is, to an extent, offset by the £150 million—do we still have a £200 million problem? That is the question, and the answer is 'no'. This offsets and reduces the scale of the problem that the NHS is facing, and the work that we are doing is to narrow and to stretch savings, so that we have an appropriate and acceptable financial resolution position this year.

[20] **Julie Morgan:** Right, I understand that then. You then said that the additional money was allocated on geographical grounds—or on population grounds?

[21] **Mr Sissling:** Martin may want to help on this question again. There is a formula that we use, the degree to which it is satisfactory has been the subject of debate over a number years. However, broadly, it provides a basis upon which we can allocate money to each health board to recognise its resident population, adjusted for some factors that recognise health need. So, for example, it would be weighted towards areas with greater health needs to ensure that the money available to a health board should more appropriately meet the needs of the population. Simply to do it on a crude population basis would not be satisfactory. So, this means that each health board should have an equal opportunity to meet the needs of their population demand, driven by their population.

[22] **Julie Morgan:** Does this recognise the specialist services that are provided, for example, in the University Hospital of Wales?

[23] **Mr Sissling:** It would in a sense, in that it goes on a population basis, and the health boards then pool some portion of the money that is available to them through the Welsh Health Specialised Services Committee, which is a sub-committee of the health boards, to allow them to purchase those specialised services in Wales, and beyond, where it is appropriate to do so. So, there would be recognition, because it is based on population—so, in a sense, it is providing it to health boards, particularly in respect of their population responsibilities, almost as purchasers and commissioners of services.

09:15

[24] **Jocelyn Davies:** I just wanted to pick up on something you said then about how you would prefer it, obviously, if the local health boards accepted that it was a settled budget, and they should manage within it. How do you think the Minister for Finance feels when, every year, you come back and ask for more funds, and you do not have a settled budget? You ask for extra funds. When you made that bid for extra funds to the Minister for Finance, did you detail to her, as you have to us, what it was going to be spent on?

[25] **Mr Sissling:** Just to be clear about the interaction, the discussion is very much between our Minister, the Minister for health, and the Minister for Finance. So, in terms of the interaction, it involves very close effective working at a ministerial level.

[26] **Jocelyn Davies:** The point that we are making is that the health budget does not seem to be a settled budget every year, because every year there seems to be more money coming from central funds to it, although you expect and prefer local health boards, as you have just said to us, to live within what they have been given, but your department does not.

[27] **Mr Sissling:** Last year, we certainly did live within our means, as we have seen from the report in front of us. The health budget as a whole was able to accommodate the pressures within the health service, so, just to make a factual point about last year, we did live within the means provided to us, which we know are stretched. In terms of this year, we felt it appropriate, of course, to stretch and use every penny of every pound. It became apparent at an early stage of this year that, looking through the lens of quality and safety, there were particular pressures, and we felt it was appropriate, and the Minister felt it was appropriate, to enter into discussions with the Minister for Finance on those issues.

[28] **Jocelyn Davies:** And you detailed to the Minister for Finance, the same way as you have to us, what that money was going to be spent on.

[29] **Mr Sissling:** Absolutely.

[30] **Aled Roberts:** Rwyf eisiau gofyn cwestiwn am y gefnogaeth allanol. Rwy’n meddwl y byddai’r cyhoedd yn disgwyl bod rheolwyr o fewn y gwasanaeth iechyd yn medru rheoli yn ariannol heb gefnogaeth allanol. A ydych yn gallu dweud wrthym beth yw cyfanswm y gost o’r gefnogaeth allanol honno, a phwy sy’n talu am y gefnogaeth allanol—Llywodraeth Cymru neu’r byrddau iechyd unigol?

Aled Roberts: I want to ask a question about the external support. I think that the public would expect that managers within the NHS would be able to conduct financial management without external support. Could you tell us what the sum of the cost for that external support is, and who pays for that external support—the Welsh Government or the individual health boards?

[31] **Mr Sissling:** There were two parts to that question. Managing very significant budgets, certainly in the context of planning three-year future strategic operational plans, is challenging. I would entirely accept that it is core business for NHS leaders. I do think that it is wise that, at times, they take advantage of external support, to get expertise. The benefits of doing so, I think, are evident in Cardiff and Vale, and other health boards are taking advantage of that. I think we could argue from a contrary point of view that, if at times the NHS is a little bit too ‘We are masters of all our information and planning’, we could be accused of being a little introspective and not sufficiently open to external influence.

[32] So, we have particularly encouraged those health boards where we feel there are particular challenges, for example, with the two health boards that required some brokerage from health boards at the end of last year, we felt it was particularly important that their plans were subject to some external quality assurance, testing and scrutiny. We felt that that was good, rigorous practice. In the context of what is at stake, which is tens of millions of pounds, to bring in some external expertise we think is good value for money. In terms of the costs, they are borne by the health boards, and as such I would not have the information specifically about how much each of those exercises costs. That information would be held at health board level, but I am sure that we could very quickly get that information about the cost of that, if the committee would like that information.

[33] **Aled Roberts:** I think it would be helpful, but taking Mike’s point, there is a

suspicion here that the fundamentals as far as budgetary controls are not there, and yet the cost of financial management within the NHS is not in itself insignificant.

[34] **Mr Sissling:** I understand the point. Would you welcome that information about the cost?

[35] **Aled Roberts:** Yes.

[36] **Jocelyn Davies:** Can I just ask why that expertise does not exist within the NHS in Wales anyway? This is something that has happened every year, year on year, for many years—that there have been problems with finances in the NHS in Wales. Why does that expertise not exist anyway—at a national level or at a local level? Why do we need expert consultants?

[37] **Mr Sissling:** Perhaps I am doing us a disservice. There is considerable expertise in each health board and within the Welsh Government in terms of financial oversight and stewardship. That expertise sits not just within the financial function, but around boards, where there are independent members who have very impressive financial pedigree and background. There are processes of scrutiny and challenge within each health board. The periodic utilisation of some expertise is, we believe, appropriate. If we simply said that it is forbidden—we must, all the time, be guided by a certainty that we know the answers—I think that we could be subject to criticism. We are not saying that for every health board; we are talking about particular circumstances. I would argue in the situation of Betsi Cadwaladr, for example, that it is entirely right that we brought someone external in to look at some of its systems, to make sure that it had internal guidance, in the same way that we always welcome the advice from the Wales Audit Office, which is another point of external guidance. We look at a whole system. So, it is used judiciously and it complements, rather than replaces or substitutes, the considerable weight of expertise in the health service in Wales.

[38] **Jocelyn Davies:** You say, 'We encourage', and then you say, 'We brought someone external in'. Is it forced on them, is it encouraged, or is it suggested?

[39] **Mr Sissling:** It varies. To go through the specifics—

[40] **Jocelyn Davies:** I do not need the specifics. So, it varies depending on—

[41] **Mr Sissling:** In Cardiff and Vale, it was something that it took the decision proactively to do, and we supported it. With Hywel Dda and Powys, it was very much a requirement at the end of last year, associated with the fact that they had needed some brokerage. So, we felt that it was appropriate. We had to ask the question, 'Is this an organisation that is able to manage its own affairs in the right way in the future?' So, we wanted to get some external perspective and blend that with the perspectives that we were getting from the Wales Audit Office. With Betsi, it was more of a total situation issue in terms of the understanding of the weaknesses in its overall governance system. So, it is a mixture.

[42] **Darren Millar:** This is an interesting question in terms of external support. Is there a threshold that triggers that external support being offered and then required? Is there a specific procedure, for example?

[43] **Mr Sissling:** It is not formulaic, in the sense that I could say that there is a perfect algorithm. At times, quite appropriately, I think, there is an element of judgment. The trigger for us—the factual triggers, rather than the theoretical triggers—was the fact that those health boards, at the end of last year, required brokerage from other health boards in order to balance. In the case of Betsi, it was clearly triggered by a more general concern about board-level governance. As we know from the report, there were particular issues about the way that

some of the financial interactions were working within the board and, indeed, the absence of a robust, rigorous long-term plan. What we would want to see more often is health boards making decisions for themselves, in the way that Cardiff did. It decided, through its own processes and its own board governance, that it was at a particular point where it needed some external expertise to guide it.

[44] The other thing that I would say, which is important, is that this is about short, sharp insight. This is not sitting on people's shoulders for months. This is very much a brief interjection of external expertise, quite often for a number of days, rather than weeks or months, to provide a snapshot. It can only be a snapshot insight. For example, the report that I read last night about Powys, which was produced recently, is incredibly helpful in setting out some of the factors about the long-term challenges facing Powys and some of the underlying pressures that will need to be managed in the future.

[45] **Sandy Mewies:** I am afraid that I am going to recap slightly. I think that this is what you are saying: Betsi has been mentioned, but, in fact, other boards are in need of additional support and are having it. You are saying that money has been allocated to them. In terms of external support, let us be fair, local government often calls in people. It is a good thing, sometimes, to have people looking from the outside in and seeing what people are doing, particularly if problems have been identified. So, what you are saying is that, at the end of all that, health boards and the trust are absolutely clear that, when their budget is set, that is it. It is set and they should not assume that extra money will be coming in. I understand that there might be an outbreak of bird flu or something else happening; I am not including those special circumstances, which nobody can predict with any certainty. However, rather than there being what seemed to be a feeling of, 'Yes, the budget is agreed, but we will always find a bit of something from somewhere', are the three of you satisfied that health boards and the trust are now clear that when the budget is set, it is set?

[46] **Mr Sissling:** Yes. My best answer to that, and, again, others might want to respond, is this: that is the requirement that we set of the system looking forward. We now have an understanding of the financial budgetary context, not just for this year, so it is not just a six-month ask, but for the next two years. Health boards are developing very strong plans to deliver within the context of that. That planning arrangement will be predicated exactly on that rigour and that discipline. So, this will not be, in a sense, a starting point and some perpetuated series of discussions and interactions; this will be a sign-off. The plans that they have produced are now on their third iteration and they will conclude in January. The plans, in a way that is different from the past, will be based on service and workforce financial plans. They will not just be plans that sit, with all due respect, in the hands of financial leaders; they will sit equally in the hands of the clinicians and those managing workforce. Kevin, in particular, is co-ordinating work to make sure that those plans are, again, subject to some scrutiny and quality assurance. When they are signed off, they are signed off.

[47] **Jocelyn Davies:** You explained that the extra funding was distributed on a population basis, so that meant that the Aneurin Bevan board got £10 million when it did not need anything. So, what did we get for that £10 million?

[48] **Mr Sissling:** Just to be clear about the £10 million, are we talking about 2012-13 or 2013-14?

[49] **Darren Millar:** We are talking about 2012-13.

[50] **Mr Sissling:** Okay.

[51] **Jocelyn Davies:** It said that it did not need any extra money to balance its books and then it got extra money. So, what was that for?

[52] **Darren Millar:** As it has, of course, this year.

[53] **Mr Sissling:** That is last year's issue, where we took a slightly different approach. There has been an evolution, so I should clarify that for the benefit of the committee.

[54] Last year, it was not on a population basis, and it was non-recurrent money. It was later in the year and it was based on an assessment of risk within each of the health boards, particularly in the context and the oversight of unscheduled care pressures. At that point, Aneurin Bevan was forecasting to break even, whereas other health boards were forecasting, say, a £10 million or £12 million deficit. When we got below the surface of that, it was actually carrying equally significant risks within the health board, but it was in a position where it was telling us that it was going to try to manage the risks, rather than putting them into its forecasted out-turn. So, our assessment was that it had the same level of unscheduled care pressures within the system.

[55] Rolling that forward, however—and this is a credit to the health board—it was in a position, through its management, which, to an extent, is a lesson to be learnt by other health boards, to drive forward on the basis of 'Let's focus on breaking even, rather than positioning risks in the forecast'. It was able to generate a surplus at the end of the year of—

[56] **Mr Sollis:** I think that it was around £2.3 million.

[57] **Mr Sissling:** That assisted us in bringing the whole of the NHS corporately into balance. So, in a sense, what we got was a—

[58] **Jocelyn Davies:** So, really, it was in the same position as the others, it was just that it was saying that it would break even, but there was something that the others were more up—

[59] **Mr Sissling:** Our conclusion is that it had the same risks. There is also, within this, to make sure that we do not create any disincentive to organisations that are delivering the best performance, we want to make sure—and this is where we are moving to capitation, so that—

[60] **Jocelyn Davies:** You do not have to treat health boards like children in that if they are good, you give them something extra, and that you do not just reward the naughty behaviour. They are not children and surely they understand that if they break even, that is great. Are you saying that local health boards would say, 'If we overspend, we are going to get bailed out, so we might as well overspend. There is no point in us breaking even'?

[61] **Mr Sissling:** Quite the opposite. All organisations are driven by a sense of professional pride in breaking even and using the money that is available to them. However, we want to move to a position, as much as possible—which is where we are at the moment with regard to the ministerial decision—of allocating money on a population-share basis, rather than simply trying to mark the projected deficits. That moves us to a position where there are different incentives and the right kind of acknowledgement of good performance in the system.

09:30

[62] **Jocelyn Davies:** I can see why there are mixed messages.

[63] I would like to ask you very briefly about clinical negligence. You will know that there was an overspend in 2012-13; why is there so much negligence?

[64] **Mr Sissling:** I might ask Martin to say one or two words, if that is all right.

[65] **Mr Sollis:** The cost of clinical negligence has moved from £58 million in 2011-12 to £70 million in terms of what we are funding centrally. It is a really complex process, and I will not go into the technicalities of the provisions and the way in which the claims are settled. Inevitably, it is a national picture. People are becoming more claim conscious. There are differences in terms of the settlement structures that are now set up. Some of these things take time to filter through. You only need small numbers but they are large claims. Therefore, the variability in terms of that element is quite significant, and the timing of the settlement and the announcement of that settlement is dictated. We have regular meetings with the Welsh risk pool to look at those. I have a meeting later today to go through the current financial position on those things. There are governance arrangements to learn lessons from all of those issues, and those are fed back through the Welsh risk pool board to see why those claims have come forward and to identify lessons that can be learned from the negligence claims themselves. Those are fed back in. However, the timing and the volatility of those things are recognised on a national basis, and, once again, people are becoming more claim conscious and are driving some of those costs up nationally.

[66] **Jocelyn Davies:** Yes, but for any claim to be successful, there had to be negligence, someone had to be damaged, and there had to be a loss to those people. So, what you are telling us, really, is that people would have been entitled in the past, but they did not know that they were entitled.

[67] **Mr Sollis:** More and more claims are being submitted in relation to this and there is more awareness of these issues.

[68] **Jocelyn Davies:** Or there is more negligence.

[69] **Mr Sollis:** Those things are looked at carefully in terms of negligence and the governance arrangements that sit around individual claims. Those lessons can take some time to come through in terms of the claims and the settlement of those claims, but there is a robust governance process in place to look at the lessons learned from all of those issues.

[70] **Mike Hedges:** I would like to talk to you a little about the health boards that required additional brokerage at the end of 2012-13. I have two questions. First, they had the brokerage; why have the other health boards not overspent, because they could have got the brokerage anyway? What incentive is there for people, apart from professional pride, at director level? For the average consultant, what incentive is there, at an operational and managerial level, not to overspend? Secondly, my understanding—please correct me if I am wrong—is that the problems are not in primary care nor in dentistry, but in certain specialties in certain hospitals.

[71] **Mr Sissling:** The first question that you asked is one that plays into the governance of organisations and the expectation, which is reasonable in public service, that resources are used appropriately, that budgets do mean a limit to expenditure and that they become a fixed parameter in the way that decisions are made about expenditure, and that it sits within the context of a managerial construct that has clinicians increasingly in points of leadership, because we know that most resources are consumed by decisions that clinicians make, so we need to involve clinicians. That is why we have clinical directorate structures in virtually all of our organisations, where clinicians can be held to account for the expenditure in their particular areas and why we have managers at all levels who work within a context of managerial responsibility and accountability, which means that there is the rigour and the discipline. The notion that there is some lack of observance of budgets is wrong. That is certainly not my experience. The whole system would be all over the place, to be honest, and that clearly is not the case in terms of our performance.

[72] Could you repeat the second question that you asked?

[73] **Mike Hedges:** I have forgotten what the second question was.

[74] **Darren Millar:** It was whether there are certain disciplines that are part of the service where there are particular problems.

[75] **Mike Hedges:** Yes. Is this happening in certain specialties within certain hospitals? I think that primary care and dentistry are about even, and that the problems seem to exist in certain hospitals within certain specialties.

[76] **Mr Sissling:** I might ask Martin and Kevin to say something. My take is that the pressures overall are probably within services rather than locations. So, unscheduled care is a service that ultimately hits hospitals, but also creates pressures in community and out-of-hospital areas. The demand for that has driven the pressures that we are now trying to accommodate. The analysis that we have offered shows that there are all kinds of very solid reasons, of demography and different prevalence of diseases, which are causing those kinds of pressures.

[77] The important point to raise—I will ask Martin to talk further about this—is increasing understanding of how resources are consumed. It is fine saying that it is a £1 billion budget and that there are chunks of £200 million, but we now have systems in place that can allow us to identify resource consumption at a much more granular level, almost at a service and patient level. Do you want to talk about the work that we are doing, Martin?

[78] **Darren Millar:** If you can be brief, because we need to get through the questions.

[79] **Mr Sollis:** The patient costing information is key in terms of clinical engagement. A lot of our emphasis is now driving towards that, so that we can have that engagement in terms of where the costs lie, so that the clinicians become owners of that information and drive the behaviours. To answer the question, the development of information is key to us. Every specialty has cost pressures as well, so we have to recognise that different cost pressures affect different specialties. Some of those, particularly high-cost, non-pay type of goods and services, can affect some services more than others. However, I am not aware that there is a general consistency in the cost information that we produce that would suggest certain specialties are worse than others, but there are different cost pressures that affect them.

[80] **Aled Roberts:** Rwyf eisiau symud ymlaen at y broblem o gyflawni arbedion. Mae adroddiad yr archwilydd cyffredinol yn dangos bod gostyngiad o rhyw £100 miliwn rhwng 2011-12 a 2012-13 yng nghyfanswm yr arbedion. Beth yw'r rhesymau dros hyn?

Aled Roberts: I want to move on to the issue of achieving savings. The auditor general's report shows that there was a fall of some £100 million between 2011-12 and 2012-13 in the total savings made. What are the reasons for this?

[81] **Mr Sissling:** On the pattern of savings, we have done some analysis that shows that, over the last four years, the level of savings in percentage terms in 2010-11 was 4.6%, in 2011-12 it was 5.2%, in 2012-13 it was 3.4% and this year it is 3.5%. So, you are right—there was a drop in the last year. Our take in looking forward is that it would be unwise to plan on the generation of savings to a level in excess of 4% or 5%; we think that it is more appropriate to plan on the level of something like 3% to 4%—where we are at the moment. Our assessment is that the generation of savings at the level of 5.2% was quite an extraordinary achievement. Perhaps it was not sustainable year in, year out to generate that level of savings. We now have more of a realistic norm, perhaps, for planning purposes. If we said each year that we could generate 5% to 6% of savings just as a means of creating a sense of balance in an equation of financial assessments, it would not be wise. Our assessment of the realistic

ability to create cash savings rather than those that are based on degrees of cost avoidance is that it is much more appropriate to base it on the level of savings that we are seeing at the minute.

[82] **Aled Roberts:** Mae'r cynlluniau ar gyfer 2012-13 yn cynnwys arbedion o rhyw £57.5 miliwn ar gostau'r gweithlu. Pa mor realistig yw hynny? O edrych drwy'r adroddiad, mae'n ymddangos bod nifer a chostau'r gweithlu yn cynyddu, eto mae'r targed yn aros yn ei unfan. O ran adroddiad Francis a phethau felly, mae awgrym bod niferoedd ar wardiau yn cyfrannu at broblemau ymhellach ymlaen.

Aled Roberts: The plans for 2012-13 include savings of around £57.5 million on workforce costs. How realistic is that? When you look at the report, it appears that the number and costs of the workforce is increasing, yet the target remains the same. In terms of the Francis report and so on, there is a suggestion that numbers on wards contribute to problems later on.

[83] **Mr Sissling:** It is a good point, and I acknowledge that it is an area in which there is a degree of work in progress in terms of workforce planning. The planning process, as I described earlier, has been exposed as an area that I think we need to get better at. That is the first thing that I should say openly to the committee.

[84] However, one point of reassurance that we took from looking back at last year was a saving in excess of £10 million in respect of locum costs. We know that locum costs are not just a cost in terms of finances, but also they do not necessarily provide the best quality and continuity of care. In a sense, that is good news. While the overall workforce employed numbers remain static, we are able to bear down on locum costs. We also reduced, and continue to reduce, management costs. That is not to say that we do not need good management—as we have discussed previously—but, over the last three years, we have reduced those costs by £35.1 million. We think that it is appropriate that we focus on clinical staff, because that comes back to your point that, if we are talking about quality and safety, surely that has to be driven by having the right number of clinical staff working in the right way in patient-facing roles. One of the sub-dimensions to that is to make sure that we have the right skills mix—the right flexibility—between clinical staff. While we obviously need to have the right number of staff, it is reasonable to reassure our professional clinical colleagues that we are working in the right way in terms of making sure that we have the right deployment of skills, professional competence and expertise against the needs of the patient. There is work that can be productively taken forward in that area.

[85] **Aled Roberts:** A ydych chi'n fodlon bod cysondeb rhwng y byrddau iechyd yn y ffordd y maent yn ymdrin ag arbedion achlysurol—*non-recurrent savings*? Mae gwahaniaeth mawr yn y ffigurau o fwrdd iechyd i fwrdd iechyd, ac efallai nad ydynt yn adrodd yn ôl ar yr un pethau.

Aled Roberts: Are you content that there is consistency between the health boards in how they deal with non-recurrent savings? There is a great difference in the figures from one health board to the next and they may not be reporting on the same things.

[86] **David Sissling:** I would concur with that to an extent. Again, that is something that we are addressing. I spoke earlier about a national approach that we need, to make sure that we build on best practice. The group, that I will be meeting for the first time next week, will be looking at a number of issues such as that. It will also be looking at things like how we can take the best advantage of the procurement opportunities—we work on an all-Wales basis already, but we can take those further. We will be looking at other aspects of reporting, other areas where we can work across health boards and trusts, with Welsh Government also involved, making sure that we have the right opportunities and benchmarking, making sure that best practice is not something that transmits itself in an elongated journey, but is very rapidly disseminated and adopted locally.

[87] **Darren Millar:** Very briefly, Sandy, then Jenny.

[88] **Sandy Mewies:** I take your point that there will be one-off savings that can be across the board, but there will be one-off savings that will not be across the board, because boards and trusts should be looking at what they have done in the past. If a board has been making huge mistakes in one area, and then rectifies them and has a one-off saving, it will not necessarily apply to another board. Are you saying that there can be consistency in some one-off savings? They are, by definition, one-off savings, are they not? They are non-recurring. In some areas there will be no consistency, and perhaps it is in those areas that good practice should be shared.

[89] **David Sissling:** You have said it; that is absolutely spot on. The main responsibility for health boards and trusts is to develop their own balance of recurrent and non-recurrent savings. We do believe that there are some areas where it is, in a complementary way, appropriate to look at an all-Wales level, to see whether we can bring best practice to bear, or whether, simply by working together, we can generate additional savings or improvements, or avoid costs.

[90] **Jenny Rathbone:** The auditor general's report points out that there was a significant reduction in elective activity in the final months of 2012-13. How much was that to do with poor management of unscheduled care? How much was to do with attempts by boards to break even?

[91] **David Sissling:** I will start, and Kevin may add to it. The position, as winter developed—as in other parts of the UK—was one of unprecedented pressure. Analysis, both in Wales and in other parts of the UK, has confirmed that there was a combination of factors, some demographic and some to do with the weather—it was a particularly harsh winter—that caused very significant pressure on the unscheduled care systems. Health boards made clinical decisions based on the priority that they gave to the most poorly patients, who needed to be admitted.

09:45

[92] The health boards collectively invested in 310 extra beds, compared with the average of the previous year, to accommodate that demand. That is a significant investment. This was not a case of organisations avoiding the need to meet the demand that was placed on them; this was health boards taking decisions in quite extraordinary circumstances to create additional capacity. They also took a decision to postpone some elective work, simply because the beds were occupied by patients who had come through A&E departments and emergency routes. I think that they took decisions appropriately. They were using the budgets in a flexible way to meet the demands that were placed on them.

[93] **Jenny Rathbone:** Okay. So, you do not think it has anything to do with the need to break even financially, in that financial year, that they reduced the amount of elective activity.

[94] **Mr Flynn:** I am absolutely convinced, from the analysis that we have undertaken, that all the pressures that took place during those last three months, and that went on into early summer, across the whole of the UK, were the primary reason we saw a reduction in elective activity over that time. The analysis is very clear. There was a big shift in terms of the capacity that was required in order to be able to deal with unscheduled care, and it was inevitable. If you go back and look over the figures, in order to be able to have carried on with the elective activity, we would have needed something in the order of 2,000 operations over that period that were subsequently cancelled. We actually lost 2,600. So, it is clear when you see what was lost during that time that that was not to be able to get to an economic envelope

of any sort; it was to be able to provide the capacity. To be absolutely clear, there were times during those three months where we were even opening capacity that was not historically to be used for unscheduled care. We were using areas such as day-case wards and so on. So, if you actually look at the numbers, it is very clear that we were using more beds than we had used in previous years to the order of around 300.

[95] **Darren Millar:** Did you have a question on this particular issue, Aled?

[96] **Jenny Rathbone:** I have not finished yet, if you can hang on.

[97] On these 2,600 cancelled operations, have you any idea as to how much catch-up has been achieved?

[98] **Mr Flynn:** As it went on after that and through into the early summer, we are at the point now where the people waiting over 36 weeks peaked during that summer period at something around 13,000. So, we had 13,000 people over 36 weeks. We just started to turn the corner in that during the September period, and it has come down now by the order of around about 1,000. If we carry on with the trajectory that we would hope to do, assuming that there are no more winter pressures of a similar sort, we should be back to something similar to where we would have been last March.

[99] **Jenny Rathbone:** Okay. There is a very significant issue in the written evidence from Cardiff and the Vale around the contracts for staff, which it is arguing are different from the contracts that exist in England:

[100] 'Some of the workforce efficiencies would more appropriately be delivered through pay restraint or changes to terms and conditions, eg enabling 7 day working to be the norm'.

[101] Welsh pay contracts are different from the English contracts. They had better terms. So, in terms of catching up on elective activity and getting people to work on weekends to do elective surgery, to what extent is that a significant factor?

[102] **Mr Flynn:** I think that you are making a workforce point, which is that the contracts in Wales are different from those in England. My experience, from what I see, is that I do not think that that is an issue with regard to the catch-up on elective activity. It is very much more to do with what we would want to do in future, in terms of holding down workforce costs.

[103] **Jenny Rathbone:** If you want to catch up on elective activity, however, at the moment you have to pay premium rates.

[104] **Mr Flynn:** No, that is a different point.

[105] **Mr Sissling:** The health boards have all produced plans now within their capacity that will allow them to generate the activity needed to be in the position that Kevin described, and, in terms of whether they are reliant on premium rates or just better use of their core capacity, it would be the latter rather than the former.

[106] **Mr Flynn:** To reinforce the point, there is a history across the whole of the NHS, whether in Wales, Scotland or wherever, that there are sometimes waiting-list initiatives that use premium rates, which is what that refers to. Right across the UK, there is pressure being placed on that to reduce that from being the norm of how you deal with waiting lists. What it is used for is to be able to manage clinical risk, because there are times when you need to do something extra to be able to deal with patients that are at certain levels of risk. Cancer is one of those areas where you can do that. So, the judicious use of premium rates is absolutely appropriate, but what you do not want it to be is a norm in the back of the system that is

helping you get there. You want to have a balanced system, in which the rate at which people are joining the waiting list is below the rate at which you are able to treat them.

[107] **Jenny Rathbone:** Are there are differences in the Welsh and the English contracts that make it difficult for Welsh NHS boards to manage the pressures that obviously they—

[108] **Mr Flynn:** I do not quite understand the point. I think there may be two things mixed up there, around workforce and premium rates. I do not quite understand the point, so I cannot answer your question.

[109] **Jenny Rathbone:** Okay. I will pursue it elsewhere then.

[110] **Darren Millar:** How can you sit there and say that you are confident that there are sufficient plans in place to be able to meet the demand for elective surgery when Hywel Dda has just announced that it is cancelling elective procedures until April of next year because of winter pressures, which are, as yet, completely unknown? They are completely unknown and quite difficult to predict, as you have indicated in the past.

[111] **Mr Sissling:** Hywel Dda, to play out my understanding of the position, has not announced that it will be cancelling all elective work. It has decided to engage on some options that it is currently exploring, which may involve a reduction in some elective capacity for a period of time, and it has not yet taken a decision in respect of that. What it is doing is looking at the way that it can best utilise its capacity over coming months, anticipating some increase in the pressure of unscheduled care. It is looking at developing capacity in community settings out of hospital, because we know that we can, at times, become too focused on the hospital, and it wants to be in a position where it can both meet unscheduled care demand and appropriately meet its planned care demand. So, it is not across the board for all elective work; it is just looking at the moment and will make a decision—

[112] **Darren Millar:** It is my understanding that it is the orthopaedic capacity, is it not?

[113] **Mr Flynn:** I will just add to that, if I may. It is very normal to profile over the year so that you are doing more elective activity at certain times of the year than others, and that is actually the way that that should be done. So, in looking at winter, that is precisely what we are trying to do. We are trying to make sure that a balance is struck that enables us to be able to deal with winter in a more planned way, should it get bad, than was the case last year. However, to be quite honest, last year was a one in 50-year event. It is very clear from the statistics that it was, so, hopefully, we will not get there again—

[114] **Darren Millar:** So, let us get this right. When you say ‘a one in 50-year event’, you are talking about the weather, are you?

[115] **Mr Flynn:** Yes.

[116] **Darren Millar:** Okay. It gets cold on a regular basis. There is climate change and it also gets very hot in the summer, and, of course, there were unscheduled care pressures in the summer of last year as well. The Minister talked about summer pressures in the previous year being the cause for problems in terms of not being able to deal with elective capacity and get that right. Are you seriously trying to suggest to us that you are absolutely confident that the capacity for elective surgery is there and that there will not be a reduction in the number of operations undertaken in the Welsh NHS? I have to say, Mr Sissling, that it was quite clear from the health board’s statements publicly that that is what it was actually planning to do; it was planning to reduce, if not eliminate, its elective surgery capacity right through until April of next year because of pressures that nobody, frankly, was able to predict. So, I find it quite surprising that you are suggesting that there is not really a problem in Hywel Dda or

elsewhere. Are you telling us, with absolute confidence, that finances are not an issue here and that it is all about weather, unpredictable demand, and that it is, therefore, effectively out of your control?

[117] **Mr Sissling:** No, I hope that it did not come across or convey itself as that. In terms of winter—

[118] **Darren Millar:** It is all dependent on whether we have bad weather. That is what you are suggesting, Mr Flynn.

[119] **Mr Sissling:** No, quite the opposite. The planning for this winter has been very rigorous and very thorough. It has been based on an assumption that this coming winter could be like the previous winter—while that was a one in 50, it could be the same next year, so we should plan on the basis that we could have another tough winter. So, first, we need to do that; we cannot allow there to be anything other than good planning to make sure we respond. The planning is based on the establishment of processes, capacity and systems that allow us to make sure that we can meet the range of unscheduled care pressures and continue to meet planned care requirements. So, the plans are robust, they have been road-tested, and we feel that we have assured ourselves that the plans that the health boards have developed are such that we can go into winter with confidence that they are well planned. So, it is not just about weather; it is about a whole series of things, because our expectation is that there will be increased pressure over winter periods.

[120] **Darren Millar:** Aled, you wanted to come in.

[121] **Aled Roberts:** May I question this profiling? Looking at the report, is there too much citing of winter pressures when, in fact, what we have are demographic pressures? Looking at the figures for the last three years, as far as A&E admissions are concerned, the 0 to 64 figures are virtually static, and the huge pressures are actually in 65-plus. Is it not the case that perhaps your profiling, as far as the need and the demands are concerned, regardless of what part of the year it is, is not keeping up with demographic change?

[122] **Mr Flynn:** It is exactly that that the planning it is responding to. The pressure has come about because of elderly people, particularly in cold weather. They get to the stage where they need hospital treatment more than is the norm. The problem that you get with an elderly person going into hospital is that they are in hospital for a lot longer than the average. So, what happens, if you get a typical elderly patient who has perhaps fallen over and broken a hip, is that they will be in hospital for something like 14 days. In those 14 days, the average number of operations that would have been supported by that bed is five. So, the problem that you have is that trade-off that takes place in the winter. That is happening in very large numbers. We know that, during last winter, the length of stays increased across the system. You can map it, and it is to do with that elderly demographic. So, when we talk about winter pressures, we are talking about the total effect. We are talking about the weather, but you do not need extreme weather, you only need it to be cold and then what happens is that older people begin, for various reasons, to be affected by that cold, and there are huge problems outside of that, to do with people being able to keep their homes warm—there is a fuel poverty issue that sits behind it. The difficulty is that the austerity that is everywhere at the moment is such that, inevitably, the only system that will take those people 24/7 is the ambulance and hospital system. So, it is a systemic problem of where these people end up. At any point prior to that, within various systems, we could have intervened so that they would not go to hospital. The challenge of unscheduled care is how we make sure that those things are happening. It is not just a health issue, it is a social issue: it is the way in which we look after neighbours and so on.

[123] **Aled Roberts:** However, as far as the health issue is concerned, there is reference in

this report—identifying and recognising that there was an increase last year of 310 beds—as to whether the policies with regard to the reduction in bed numbers since devolution has created the current situation, the word used for which is 'unsustainable'. In fact, what you have is a double whammy: increased demand and a policy, since devolution, of reducing bed numbers, which means that, given the need for longer stays in hospital, our model is currently not fit for purpose.

[124] **Mr Flynn:** It is a complicated system. I would agree that the current model is not fit for purpose in terms of the whole system, because you need a social care system and everything else that is able to support older people in an appropriate way, and that is what we are moving towards.

[125] In terms of bed numbers, bed numbers in Wales are still above where they are in England. So, if you look at the numbers in England, there are about 2.7 beds per 1,000 of population, while in Wales it is around 3.2. Wales is very similar to Scotland and Northern Ireland in terms of the number of beds. The reductions that have taken place over recent years are much the same across the whole of the UK. Those reductions are all on the back of improvements in length of stay around planned procedures, elective activity and so on. The difficulties come with the unscheduled care system. We get these peaks, and the problem is that you cannot keep all those beds open all the time. You get these peaks in winter when you get large numbers of older people with long lengths of stay. So, we can re-profile to try to accommodate that, but we equally have to deal with the wider systems issues at the same time, which is what the winter plans are trying to do. So, in order to be able to deal with that, we have been making sure that health boards have been meeting with the local authorities in each area. We have conducted meetings with our Minister, the Minister for local government and the Deputy Minister with each of those health boards, and we have met all of the local authorities to understand what they are doing as part of those winter plans. So, we have to see this as a whole-systems issue, and there is as much in these winter plans that is going to happen in social care as there is about bed numbers. By the time they have become a bed number, at per person in a bed, actually, some other aspect in the system may have failed and we will need to make sure that that is correct.

10:00

[126] **Darren Millar:** Okay. We are against the clock, and Jenny wants to come back in. I will bring Julie in very briefly, and then final questions will be asked.

[127] **Jenny Rathbone:** I think that you have answered it, but that was precisely my original question, which was about the poor management of unscheduled care, in the sense that, yes, somebody who breaks their hip must go to hospital, but an awful lot of other people, particularly in the elderly population, end up in hospital because other services are not working effectively. So, really, what we need to know is that health boards are managing their services across the piece so that people are not being dumped in hospital because other services are not fit for purpose.

[128] **Mr Flynn:** I absolutely agree with that, and the winter plans are aimed at looking right across that system, including the way in which it interfaces with social care and primary care, and so on.

[129] **Darren Millar:** Of course, this committee will be able to contribute to that debate in our inquiry into unscheduled care, which we are taking forward as well. Julie is next, then a final question from Oscar.

[130] **Julie Morgan:** Just very quickly, do you expect health boards to meet their targets in, for example, emergency department waiting times and in elective surgery this year?

[131] **Mr Flynn:** First of all, do we expect them to meet their targets? Where we are not already achieving targets, the aim is to try to get health boards to the point where they are improving towards those targets. So, the way in which it works at the moment is that, if you look across the whole of the targets that we have, which is something in the order of 40 targets, at any one time, about three quarters of those were in an improving position or in a position where they were achieving them, and there is about a quarter of them usually where some form of recovery action is taking place. The current situation is that most of those happen to be around access, where the recovery action is taking place.

[132] As far as it is concerned now, we have laid out what we would call recovery trajectories with health boards, working with them to be able to understand how each area of those is to be recovered, so that, if an organisation is not achieving a target, we expect it to put in place a recovery plan. We would therefore work with them to be able to do that. What we are looking for is that the system is always in some form of improvement in the way that it operates. It is inevitable with very large boards of the scale that we have that there will always be areas where there will be some degree of recovery having to take place. So, we want to take a balanced view, and the most important thing that we want to acknowledge is that one of the things that was recognised by the Francis report is that there can be unintended consequences from simply pursuing targets, because you may be focusing on the wrong thing. So, we have to be careful about how we do that. In that context, however, we are trying to make sure that they are always improving and moving towards those target positions.

[133] **Julie Morgan:** So, you would say that three quarters of the targets would be met and that a quarter would not.

[134] **Mr Flynn:** No; I said that, at any one time, we are definitely improving across around three quarters of our targets or are remaining static, and there is about a quarter where there are usually some recovery actions taking place.

[135] **Julie Morgan:** Thank you; I will leave it there.

[136] **Mohammad Asghar:** You mentioned just now, Kevin, that the current system is unsustainable in the unscheduled care. So, in the past, whatever happened, you have not learned any lessons from that, and your business is not as usual and you want to make further planning—and you are not very happy with that. So, tell us what exactly you are expecting if extreme weather comes in, and if it does not come, will you save money or will you need extra money on that?

[137] **Mr Flynn:** First of all, I think that the whole of the UK would recognise that—

[138] **Mohammad Asghar:** We are talking about Wales here.

[139] **Mr Flynn:** It includes Wales. The whole of the UK would recognise that, with the demography that we are facing, there needs to be a different long-term solution for how we deal with unscheduled care, and that is something that everybody is trying to work on in order to achieve it. I want to emphasise that it is a whole-system issue—it is not a simple issue of what happens within the health system; it is the way in which the whole system operates. So, that is the basis on which I am making the statement that, in the longer term, it is unsustainable. In the meantime, we are working with those partner organisations across that system in order to be able to do the best that we can within where the system is now, and everybody is committed to working together to be able to do that. They have verified that in those conversations that they have had with the Ministers around that, namely that they are working together to be able to achieve that.

[140] We do have to recognise, though, that the whole system is also in a period of austerity and that there will therefore, inevitably, be times when the peaks become, for transient times, things that mean that it is difficult to be able to achieve everything that needs to be achieved.

[141] **Mohammad Asghar:** I now come to the question, which is on future pressures. Your evidence paper acknowledges that the additional funding does not remove the significant pressure on NHS finances and the need for change. What is your view on the general pace of transformation of services and reconfiguration, and on whether the changes will be sufficient to make the NHS sustainable in the face of growing demand?

[142] **Darren Millar:** That is a very big question. [*Laughter.*]

[143] **Mr Sissling:** One of the most helpful observations in the Wales Audit Office report, in a sense, was that we need to go further, and faster, with some of the changes; that is what I read, and I think that we would concur with that. That is not just in terms of hospital changes, because some of the changes in hospitals are to do with issues of quality and safety—which are, obviously, important, and we need to address those—but we also need to ensure that there is no confusion with those being the financial solutions. Some of the changes that we are currently consulting on, and will be taking forward, subject to the outcomes of consultation, are not major contributors to the financial challenge that we face ahead. Much more, we want to focus on some of the things that we have just been talking about: rebalancing the system, in terms of reliance on hospital care and out-of-hospital care; ensuring that we adopt best practice where we know that we are not currently at that level, in terms of some of the clinical pathways and the clinical models of care; and ensuring that we increasingly work enthusiastically with colleagues in local authorities where we can have anticipatory, preventative care. All those allow us to address the financial challenges in a way that is not simply about cutting cost—it is about better use of resources. If we can avoid long stays, if we can reduce readmissions, and if we can reduce hospital infections, for example, they hit the mark in terms of quality, patient experience and the finances. Therefore, I suppose that my reflection to the committee is to concur with the comments that are made in the report and, while acknowledging the processes of public engagement and consultation, because these are matters of huge interest, we need to work in a way that recognises that this is something that we will be doing for several years ahead.

[144] **Mohammad Asghar:** I know that there is a cycle that you are talking about for three-year planning. Can the Welsh Government afford the likely requirement for significant investment in the early years?

[145] **Mr Sissling:** Again, in terms of the three-year financial regime, one area to which we are paying particular attention in the three-year plans is to ensure that we do not simply frontload all the financial pressures, so that everything is rosy in year three. We need to be very rigorous in ensuring that the balance is distributed, as different health boards will be in different positions. Ultimately, there is a part of this where there is a summation of each year, and we need to ensure that we can accommodate it with the totality of the resources that are available within the overall health and social care budget main expenditure group. Therefore, it is an area of real attention to us, so the answer has to be, 'Yes, that is what we are doing at the moment, and that is why we are paying such attention to the three-year plans'.

[146] **Mohammad Asghar:** Finally, how do you intend to manage the risk that the annual cycle of overspends and additional funding does not morph into a three-year cycle with much larger financial implications at the end of the three years?

[147] **Mr Sissling:** That goes to the heart of this planning process. The financial regime has to be predicated on a planning process that pays as much attention to month 1 as to month 36. Therefore, that is why the health board plans, and the trust plans, individually and

collectively, have to be affordable. It goes back to the theme that we are on the threshold of some quite significant change, and not just in terms of the planning, because the planning is a reflection, in a sense, of how services are planned and delivered. Therefore, the plans that we are asking health boards for are ones that we want to show sustainability. They are not just a question of how we can get through the next 12 months, and the further 12 months; it is not a bolting together of three one-year plans; it is a genuine three-year plan that shows an evolution in service delivery models; that acknowledges the need to provide high-quality, unscheduled care and planned care; that acknowledges that there is demand; and that acknowledges, at times, that the weather can be less than what we would want. They have to be realistic and robust plans that allow us to look to the future with the confidence that we would want in the NHS in Wales.

[148] **Mohammad Asghar:** Thank you.

[149] **Darren Millar:** Okay, that just about brings us to the end of our questions. Thank you for your attendance today. You have indicated that you will send us information in relation to the costs of external advice. May I also ask you to send the committee some information on the Townsend formula and the impact of any changes in the future that that might have on health board budgets to help inform our inquiry?

[150] **Sandy Mewies:** May I ask for some information? I think that you were talking about some analysis of what had happened exactly and some ongoing analysis. It perhaps would be useful to see all of that. I wonder whether we could have some—

[151] **Mr Flynn:** In setting up any winter planning sessions that we have been doing, there was some work done by Public Health Wales and by what we call our delivery unit. Both of those undertook an analysis of what happened over last winter. The Public Health Wales one is from the much wider population perspective and the delivery unit one looks much more at activity levels inside hospitals and what was taking place.

[152] **Darren Millar:** We would appreciate a note on the capacity issues.

[153] **Sandy Mewies:** I would like to see that.

[154] **Darren Millar:** Thank you very much for that.

10:11

Cyllid Iechyd 2012-13 a Thu Hwnt: Tystiolaeth gan Fwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro
Health Finances 2012-13 and Beyond: Evidence from Cardiff and Vale University Local Health Board

[155] **Darren Millar:** We will move swiftly on. We extended that session, but I think that it was important to be able to listen to the Welsh Government on these finance issues. As a consequence of that, we are going to shorten this next session if we can, into a half-hour session, as I am sure you will be pleased to know, Mr Cairns. I am delighted to be able to welcome Adam Cairns, the chief executive of Cardiff and Vale University Local Health Board, to the table today.

[156] **Jocelyn Davies:** I am sure that Mr Cairns is very disappointed about that.

[157] **Darren Millar:** I am sure that he is very disappointed.

[158] **Mr Cairns:** I will try to hide my disappointment. [*Laughter.*]

[159] **Darren Millar:** We are very grateful for your attendance and for the paper that you circulated to us, which Members have had the opportunity to digest over the past few days. You required quite a bit of additional funding in the last financial year. Have your feet been held to the fire by the Welsh Government, would you say, as a consequence of that? What sort of monitoring arrangements have been in place? How is it making sure that you are doing a good job in stewarding those finances?

[160] **Mr Cairns:** You will recall, Chair, that I came to visit you last year and, at that time, we were outlining the position as we found it, and we were very clear that there was a substantial challenge that the health board had to face in meeting its financial responsibilities. We have taken that extremely seriously. I would like to think that we have contributed a little to the thinking that has taken place around three-year disciplines and some of the work that we have developed around a three-year plan. So, we have been in almost continuing dialogue, as you can imagine, as our plans have taken shape. Those have been tested and we have been subject to regular reviews. Clearly, our own board is very keen to understand that it can see how, over the next two years, we get to a position where, actually, we are in a very strong financial situation.

[161] **Darren Millar:** Thank you for that. Sandy is next.

[162] **Sandy Mewies:** Thank you. The evidence paper that you provided, Mr Cairns, says that you have an agreement with the Welsh Government that you will deliver a £32.5 million deficit for 2013-14. However, that is not on target at the moment, I understand. On 6 March, it showed that this is £7 million out of kilter. So, what is your most realistic projection of the position at the year end? Could you tell us a bit more about that agreement with Welsh Government? What was it exactly? Was it a case of saying, ‘You do this; we do this’? What contingency plans do you have should the additional funding prove insufficient given that there is a wider gap?

[163] **Mr Cairns:** On this year’s position, you are right: we report very transparently where we are—the good and the bad of it—and, in the year to date, we have had a number of issues that we had not anticipated, which have hit our bottom line, and which means that we need to do more work in the final months of the year to bring this in. I need to say that it is £7 million off and the budget is £1.1 billion. So, actually, it is a very small variance and we are still very committed to delivering the numbers that we need to deliver and all of our effort is focused on making sure that that is what happens. Could you remind me what your second point was?

[164] **Sandy Mewies:** My second question was about the talks that went on around this agreement and my third point was about what would happen if you do not get it right.

10:15

[165] **Mr Cairns:** Okay. On the talks about the agreement, if you recall, what Mr Sissling was saying was that it would be a bit of a stretch to imagine that organisations could deliver much more than 3% to 4% in any one financial year. We are faced with a situation where what we actually need to save is 9%, which is £90 million of our turnover. We have produced a plan in the current year that saves £56 million, which is a little over 5.5%, and that plan will be delivered. That is what we are going to do. That plan is a good plan. It is based on lots of good evidence about where others in the UK and beyond are doing well with their own resources—the way in which they organise themselves and the way in which they deliver their services. It is based on that evidence that we have constructed the plan. For future years, we still have opportunities based on all of the benchmarking that we have done and the comparative work that we do with other organisations. It shows us that there is still more that

we could do to deliver more productively with less waste, more efficiently and, indeed, to drive up quality at the same time. So, our commitment is to continue to move forward on that basis.

[166] In terms of contingency planning for the end of the year, during November I am holding detailed conversations with all of the delivery teams in our organisation. We will be going through the information line by line, area by area. We will be looking for opportunities to do the right thing, to manage the costs that we have and to anticipate and any more that we might have. I am confident that there is still plenty of road to run and we have every reason to expect that we can deliver the numbers that we need to deliver.

[167] **Darren Millar:** Just to be clear, do you think that the additional resources that you were given as part of this £150 million package will be sufficient for you to break even by the end of the year, because the auditor general identified a bigger gap?

[168] **Mr Cairns:** No; to be clear, we think that, given the resources that we have been provided with, we will still be in a deficit at the end of this financial year as an organisation. That cannot be proved, so we will be in a technical breach—in fact, a substantive breach—of our financial duties. However, we are saying that the plan that we have constructed is, we believe, a very strong plan. It is based on sound evidence and is backed up by lots of external assurance. That plan delivers a surplus next year and a bigger surplus the year after that. That is, if you like, the construct of a three-year plan. So, to some extent, some of the changes that we are making in the current year are costs that we outlay in year 1, which, if we do not outlay in year 1, we simply have moving through each of the next two years. So, a bit of this is about spending some money now to produce a better financial position moving forward.

[169] **Darren Millar:** Are you happy with the Townsend formula that was used to distribute the cash?

[170] **Mr Cairns:** There is always debate about the right way to fund healthcare.

[171] **Darren Millar:** Are you happy with it? Is it fair and does it reflect the pressures in your health board?

[172] **Mr Cairns:** There is always room for discussion about that.

[173] **Darren Millar:** So, no.

[174] **Mr Cairns:** I am not saying 'no', I just think that there is no right answer, honestly. You could take bits of this and argue it one way or another way. It is very complex.

[175] **Darren Millar:** There will be winners and losers no matter what the arrangement and no matter what the formula is.

[176] **Mr Cairns:** Yes, inevitably. There are many moving parts and all sorts of factors that need to be taken into account. To my knowledge, there is not a perfect solution anywhere in the world.

[177] **Darren Millar:** Okay, we will move on.

[178] **Mohammad Asghar:** Mr Cairns, last year, when you came to this committee, you said that you would like to make some rapid changes, particularly in relation to unscheduled care, in order to improve services and make savings. Have you achieved something there, or have you learned some lessons? If you have, have you also shared these with others?

[179] **Mr Cairns:** We have made significant progress on our unscheduled care system. Heading into last winter, just to give you some context, the hospital part of the system was heavily congested. There was not a spare bed anywhere. Clearly, in that situation, if you get a surge, it is very difficult as you have literally nowhere left to go. What happened, as everybody knows, is that we ended up, in my view, inappropriately placing patients into elective or surgical beds, with the consequences that were widely reported. That is unacceptable to everyone, including me.

[180] Since the end of the winter, we have been working very hard with all of the clinical teams to see what we can do to make things better. The good news is that, since May, we have reduced the average length of stay for patients who have been admitted urgently or through our unscheduled care system by two days. So, despite the number of admissions going up, and continuing to rise, there are 100 fewer patients in hospital at any one time as a result of those improvements. With regard to those improvements, I would pay tribute to all of the clinical teams that have worked extremely hard to put into practice lots of what I would argue is better medicine, more timely interventions and faster treatments. In addition to that, we have seen the performance in our A&E part of the system, from a baseline of about 85% for quite some time, now reach very close to 95% in our four-hour experience of patients, despite the fact that we took a decision heading into last winter that we just needed to do something about our A&E department. If you have ever visited it, you will know that it is extremely cramped and that it is not really fit-for-purpose. For many years, people have wanted to do something about that. We decided that we would, so all of those improvements are currently being delivered with a third of our department shut, because we are upgrading it. So, I think that the clinical teams in our systems are engaging with this problem, and they are trying really hard to come up with better ways of managing patients coming through the system. I think that we can point to significant signs of improvement.

[181] **Mohammad Asghar:** Do you think that you will achieve your goals within the next three years of planning?

[182] **Mr Cairns:** I do. I listened with interest to the proceedings just before I came in, and one of the questions that someone was asking was, 'What's in it for the clinical teams? Why would they want to contribute to making improvements?' My answer to that is that there are two reasons. One is that, provided we can enter into dialogue about the quality of the care that we provide to patients and whether we can do it better—organise it more effectively, deploy evidence more consistently and do the kinds of things that we would genuinely like to do—sometimes, you have to invest a little upfront to make some of these changes happen. However, when you do that, you buy goodwill and commitment, and the quality can improve at the same time that your baseline costs go down. We are seeing that happen in the current year. So, the first thing is that you must have the right kinds of conversations.

[183] The second is that there has to be, in my view, some kind of positive incentive system in our arrangements. Last year, for example, one of the bits of our organisation went further than we expected it to; it delivered, on a satisfactory basis, better savings than we were expecting. We said to it, 'That's great; you can have a good chunk of that money back this year non-recurrently to spend on areas that you think you could use wisely to improve the quality of what you are providing.' So, we are trying to create an incentive for people to do better, so that they are able to use some of the extra money that they are able to release to re-invest in their services. If you put those two conversations together, you start to build will around improving the quality of what we are doing.

[184] **Darren Millar:** Julie wants to come in, and then we will come to Jocelyn and Jenny Rathbone.

[185] **Julie Morgan:** That is very encouraging—[*Inaudible*.]—two days and a 100 fewer

patients in hospital. Are you able to give us the figure for patients who are waiting to go to other forms of care—patients who we traditionally refer to in terms of 'bed-blocking'—as of today?

[186] **Mr Cairns:** I should have explained to the Chair as I arrived that we have a board meeting today, and I have not brought colleagues with me for that reason, so there may be one or two details that I may need to come back to you on. The general position on what we would call 'delayed transfers of care' is that it has improved. I am very pleased to say that the working relationships with both of our local authorities are excellent; they are really good, and together we have invited the King's Fund to visit Cardiff. We wanted it to give us the benefit of its learning from how systems have integrated across the UK, and to give us an accelerated opportunity to draw on that experience and to deploy that learning from elsewhere. We are doing that. We have created a senior leadership team, which involves the leaders and chief officers of all the organisations concerned, and we have a plan in place. It is very practical—it sound very prosaic, but it involves getting teams in social care and healthcare to sit in the same building together to share some of the same technology, and to work more closely around the people who they are serving, but, of course, there is a huge overlap between health and social care. So, we are doing all of that, and I pay tribute, again, to the teams that are taking that work forward. I think that we are seeing positive signs of improvement in that bit of our system.

[187] **Julie Morgan:** Would it be possible to send us some figures to show how it is going down?

[188] **Mr Cairns:** Yes, sure.

[189] **Jocelyn Davies:** Last year, you were more reliant on non-recurring savings than other local health boards, and I am sure that you would be the first to admit that that is not sustainable. So, how realistic are the assumptions in the paper that you sent us that all of your savings this year will be recurring?

[190] **Mr Cairns:** One of the very important signals, I think, that the system is sending to health boards and all this talk of moving from a one-year to a three-year financial regime is extremely powerful, because it moves us away from a focus on the end of any one year. When you focus on a single year, boards' minds inevitably get very focused on 31 March, and I think that that tends to diminish the focus on the underlying financial position, because you are trying to get over the line each year. So, in our situation, we said very openly, 'This is the size of the challenge that we have; here is the underlying position that we have to deal with, and here is a plan, over three years, that works that through, so that we get into a position, realistically, where that position is managed'. So, I am confident that the plans that we have set are ambitious and stretched. Spending literally £56 million less to deliver the same or better care is a big challenge. There is no question about that. However, we have 60 schemes or so that we are running, each of which have a significant degree of evidence beneath them that should give us confidence that we are trying to do the right thing. So, I am pretty confident that the current year plans are good plans.

[191] **Jocelyn Davies:** Are they very detailed?

[192] **Mr Cairns:** They are.

[193] **Jocelyn Davies:** Do they identify specific initiatives?

[194] **Mr Cairns:** They do.

[195] **Jocelyn Davies:** Okay. As for your budget holders, I am sure that Mike Hedges will

be interested in them. You do not manage the whole budget, as you have budget holders, but are they all signed up and accountable?

[196] **Mr Cairns:** Yes. You talked earlier about whether we had any external help. We did. As for why we took the decision to get some extra help, there were three reasons, really. The first is that I needed to understand how we got into a position of not in a recurrently balanced position. The second was to understand how we could get to a situation last year where we delivered the very best possible result that we could. Thirdly, and most importantly, we needed to understand how we could build our way out of that system, or that situation, with robust plans that drew on the evidence from around the world and across the UK of what others are doing that we could learn from. So, we used all of that and we built our plans, bottom up—to use that cliché—with our teams, and we asked them, 'Here is how you are different to other parts of the UK. Can you explain that?', 'Why are you so different?' and 'What can you do to close the gap and how can we help you to do that?' Those plans are challenging. Change is really difficult to deliver, but those plans were built in that way. So, it was not me sitting in an office thinking, 'We could do something different'; the plans have been very much based on the dialogue about where the opportunities are and how we can build our way through, delivering against those opportunities.

[197] **Jocelyn Davies:** So, each of your budget holders has to stick within those spending plans?

[198] **Mr Cairns:** Yes. They all know exactly where they are.

[199] **Jocelyn Davies:** Do you hold them accountable to that?

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

[201] **Jenny Rathbone:** I want to look at the comments that you made about your workforce plans and reducing staff numbers over the next three years. Mr Sissling was slightly coy on this, but I would be really interested for you to explain how your plans to reduce the workforce costs fit in with the Francis agenda.

[202] **Mr Cairns:** Sixty-one per cent of our influenceable costs are people costs. It would be inconceivable for me to sit here and say that we can deliver all of that and still have exactly the same number of people working in an organisation being paid exactly the same going forward. That would be intellectually dishonest. I cannot and will not argue that. The question is whether we could find a way of delivering the same or better quality of care by organising ourselves more effectively by delivering services more intelligently and by focusing on the evidence and on what that tells us. The answer to that question, I think, is a very large 'yes'.

[203] To go back to the example that I cited earlier, no-one, least of all the patient, wants to stay in hospital any longer than is absolutely necessary. So, we could choose to keep people in hospital for an extra two days. We would have to staff those wards. We would have to feed the patients, clothe them, and wash the sheets, et cetera. Therefore, rather than do that, we are saying, 'Actually, if we can get people home to where they really want to be much more quickly, is that not good for everyone?' So, of course, as we do that, we need fewer ward beds. As I have been saying to everyone, that means that we can spread the jam that we have less thinly; we can focus our resources into the areas that we have left and make sure that those areas are as well staffed as we can possibly make them.

[204] So, overall, in my view, there is no conflict between having really well-established wards, but fewer beds, because what you are trying to do is either to avoid people coming into hospital in the first place, by offering them alternatives, or, when they do have to come into hospital, making sure that they get what they need much more quickly, and are able to return

to where they want to be, which is at home—with support if necessary—much more quickly. I think that that is okay.

10:30

[205] **Jenny Rathbone:** I think that that is excellent; I absolutely agree. That is very clear. I am interested in pursuing some of the other issues that you raised, namely the consultant contract, the agenda for change and the GP contract. You are saying that the English contract is on significantly better terms for employers. I wondered whether you would just elaborate on that.

[206] **Mr Cairns:** There are differences; that is a matter of fact. When you look at the consultant contract in Wales, we estimate that it is around 14% less cost effective than the English contract. That is to do with the way in which the sessions are calculated and the expectation about the number of parts of the week that a consultant might spend in supporting clinical activities rather than delivering direct clinical services. There are differences. On the agenda for change in Wales, there are some key differences. For example, if you change someone's role, you follow the right route and the right process, and you redeploy that person into a new situation—let us say that you do not require all of the skills that they previously had, and that you are effectively putting them into a lower graded post—in Wales they can have up to 15 years of pay protection. You can make the change, you can go through all of the difficult tasks associated with that, but actually, from a cost perspective, nothing happens for 15 years. That is not what happens in England. Those arrangements are different.

[207] **Jenny Rathbone:** How different are they?

[208] **Mr Cairns:** I think that it might vary a little across the piece, but you might be looking at two years, rather than 15, for example. If you make a change, you could begin to see those cost savings coming through within a shorter time frame than is the case in Wales. There are differences, and I understand why they are there. All that I am saying is that if we want to face the facts—and we do—we have to get by with the resources that are available to us. That means that we have to do the kinds of things that I have been talking about. We have a mix in here that is available to us. We can have fewer people overall, or we can have an average cost that starts to fall. The average cost can fall through skills-mix reviews or it can change through redesigning the way that we deliver services. We can also affect costs by changing some of the terms and conditions, and I think that that is a legitimate question for us to ask at this stage.

[209] **Jenny Rathbone:** Is this something that the health board can pursue on its own, or is it something that has to be done across Wales?

[210] **Mr Cairns:** It has to be done across Wales.

[211] **Darren Millar:** Where does this figure of 14% come from? Is it a figure that is recognised or is it just calculated elsewhere?

[212] **Mr Cairns:** It is a figure that we have calculated.

[213] **Darren Millar:** You have calculated it.

[214] **Mr Cairns:** Yes, we have calculated it ourselves, based on our own analysis. It may be subject to a little bit of challenge, but I think that it is a reasonable view.

[215] **Darren Millar:** Will you send us a little more information on how you have calculated that? I think that it would be useful.

[216] **Mr Cairns:** Of course.

[217] **Julie Morgan:** I have a question on workforce reduction. Obviously, this is causing concern among the workforce. I think that you say in your written evidence that a further reduction of 380 jobs is expected by the end of March 2014, following an earlier reduction of 180 jobs. It is very understandable that the workforce is concerned about this. Could you tell us how many of those job losses are likely to result in compulsory redundancy?

[218] **Mr Cairns:** We started the year with a plan to reduce our workforce by around 380 posts. It is really important to say that we did not start by asking 'How many fewer people do we need?', and working back from there. We started by asking, as I have explained, 'How are we different from other parts of the UK? How can we explain that, and what can we do to be more like they are?' As a result of those pieces of work, we were able to see that we would not need as many people if we worked in the kinds of ways that others were working. It was that way around. It has been a very controversial exercise. Not everyone has agreed with the way that we have gone about doing it. We took legal advice. It is clear that the section 188 issue, which people will be aware of—it is a piece of trade union legislation—is designed to protect employees' rights. We are required to issue a formal notice if it is possible that more than 20 posts might be affected by any change. Given that we knew that there could be up to 380 people affected, we felt that there was no choice but to go down that route, which is what we did. Over the course of the months since we made those plans explicit, we have been working closely with our trade union partners, and I think that we are looking at fewer than 10% of those now being required through any form of compulsory redundancy. We have worked very hard to avoid the necessity for that. We have redeployed people, we have offered people voluntary early release, we have reconfigured roles and we have looked very hard and critically at our turnover so that we are managing our in-flow of new people as well—clearly, we have been holding vacancies back so that we can move people around into vacant jobs. So, we have done all of that and, while we are still finalising the numbers, it is a much smaller number of compulsory redundancies that we will need.

[219] **Julie Morgan:** So, you are talking about 18 compulsory redundancies.

[220] **Mr Cairns:** The numbers are somewhere between 20 and 40. It is something of that order.

[221] **Julie Morgan:** What is the attitude of the trade unions?

[222] **Mr Cairns:** Look, I do not relish the thought of having to issue a compulsory redundancy to anybody, least of all to someone who is giving their service to the NHS. So, we are doing everything that we can to avoid that necessity. We are working closely with our trade union colleagues, and in Cardiff and the Vale, while there is a difference of view about the world and what needs to happen, I would say that we are working very constructively, albeit we have a point of departure at the very beginning of the conversation that we are having.

[223] **Julie Morgan:** I understand that, but we also represent some of the people who may lose their jobs.

[224] **Mr Cairns:** I do not take any pleasure in this at all. However, I was listening to the proceedings earlier, and I think that it is right that there is a budget, and we are asked to work with that budget. We have a responsibility to ensure that we do. We have to make sure that we are driving quality up, and, in the end, 61% of all of our influenceable cost is people, and I think that it would be hard to see how, in making changes, you could avoid some of the circumstances that we are in, given the scale that we need to deliver.

[225] **Darren Millar:** To be clear, you have been given an additional £20 million in the current financial year that you were not expecting earlier in the year when you planned these losses in terms of the number of staff. Does that not change the game?

[226] **Mr Cairns:** Bear in mind that our starting position was that we were going to be in deficit by £32 million. So, the extra resource that we are getting makes that deficit smaller. That is good news going forward, because our recurring resource base is better than we were assuming for next year. It does not really change the outturn for this year, because we have to get as close as we can to a break-even position this year. We have simply been saying that, on the basis of our plan, it would have been £32.5 million, but now it is likely to be somewhere between £12 million and £16 million. We are working through the assumptions—

[227] **Darren Millar:** Yes, but on the basis that you were able to manage with £20 million less and that you now have £20 million more, does that not change the game over the three-year period?

[228] **Mr Cairns:** Over the three years, it certainly does.

[229] **Darren Millar:** So, are you not able to review and reflect on that?

[230] **Mr Cairns:** No, because next year, and the year after that, we still have to make substantial reductions in our underlying cost base to get into a recurring balanced position. So, it means that the plans that we have going forward are offset to some extent by the recurring nature of this settlement, but it does not at all take away from the requirement for us to substantially lower our cost base over the next two years.

[231] **Aled Roberts:** Os ydym yn symud at ostyngiad mewn triniaethau dewisol yn ystod 2012-13, i ba raddau yr effeithiwyd ar y gostyngiad hwnnw gan y pwysau ariannol ar y gyllideb?

Aled Roberts: If we are moving towards a reduction in elective surgery in 2012-13, to what extent was that reduction affected by financial pressures on the budget?

[232] **Mr Cairns:** That is an important issue. From our perspective, during the period at the height of all those cancellations, it was the last thing that we wanted to do. It was not a part of our financial plan because that, in my view, is an extremely short-sighted manoeuvre if that is what you do. Those patients still need to be treated and it is quite likely that it will cost you even more money, because you will have to do it in premium rate time and all the rest of it. The reason why we cancelled as many patients as we did is for the fact that I explained earlier: we simply had little or no surgical capacity and, when we were overtopped with demand, those patients unfortunately went into the surgical elective bed base. That meant that we were physically unable to get patients into the hospital. That was our problem.

[233] **Aled Roberts:** A ydych yn ffyddiog felly, gan eich bod wedi dweud eich bod wedi lleihau'r galw am y gwelyau hynny, y bydd gennych gapasiti eleni, os oes pwysau tebyg ar welyau, ac y byddwch yn barod i ymateb i'r galw hwnnw?

Aled Roberts: Are you confident therefore, given that you have said that you have reduced demand for those beds, that you will have capacity this year, if there is similar pressure on beds, and that you will be ready to respond to that demand?

[234] **Mr Cairns:** The demand has not gone down; the demand has gone up. That signals to us the need to do even more work, looking at pre-hospital care and primary care. I am sure that there is more room for improvement in that part of the system. What I am saying is that we have found a way of managing that demand more efficiently, which has led to us needing fewer beds than we needed this time last year. The good news is that that means that we now

have some surgical capacity and empty beds that we can plan to bring online should we get more demand during the winter. That is part of our plan for this year. All other things being equal, we are in a better place, by virtue of the changes that the clinical teams have delivered, this time than we were at the same time last year, because we have more capacity.

[235] **Aled Roberts:** Out of interest, how many elective treatments were cancelled in your health board area? Where are you in terms of catching up?

[236] **Mr Cairns:** Through the entire winter, we lost about two weeks' worth of elective surgery in total. That is a lot. We are aiming, by the end of this financial year, to have delivered this year's activity and put that back. So, we should end this year with only a small improvement on the position that we started with a year ago, but we will have got back to where we started. Clearly, our plans going forward are then to eat into that and to make that better over time.

[237] **Darren Millar:** Mr Cairns, many people will find it incredible that your health board is in a situation where you have cut the staff numbers by 180, with a further 300-odd to go before the end of the financial year, and you have increasing demand on services, but that you expect to be in a position to be able to reduce your waiting-time base. When we look back in May, and the figures are published for April, will you be eating your words?

[238] **Mr Cairns:** I very much hope not. Bear in mind that our workforce plans are not all about clinical staff, by any means. We have set a goal of reducing our corporate overhead by 10%, which is not a front line at all. I think that that is an appropriate thing for us to be focusing on in these times. I am not pretending, and it is not part of my presentation to you today, that this is straightforward or easy. It is very complex and there are many moving parts. However, there is a prize: if we can get our clinical teams to focus on doing the right things consistently, using the evidence, if we can build some incentives for them and if we can continue to demonstrate that care is improving, as I think we can at the moment, we can build will. I do not think this is only a board level challenge; this is a task in which we have to engage our entire workforce. We have to get the whole of our organisation behind delivering the challenge that we face.

[239] **Julie Morgan:** In terms of prioritising what you concentrate on and what you do not, and in terms of guidance and support from the national Government, what comments do you have about that?

10:45

[240] **Mr Cairns:** The Government provides us with the resource that we have to do the job that we need to do and there are commitments that we sign up to deliver as part of that process, including the targets that are set, and there is a level of maturity about the discussions that we have about delivering targets, because, I am pleased to say that, in Wales, we do not work in a climate where—I have worked in places where it is the case—the target is an all-consuming activity. So, we are not in danger of not seeing the wood for the trees. It is really important that we keep standing back and asking ourselves, 'Are we continuing to do the right things?' However, overall, I think that the dialogue that we have is challenging—it is supportive where it needs to be, but it can be very challenging, appropriately, in my view. We are not in any doubt about what we have to deliver. We know what the expectations placed on us are.

[241] **Julie Morgan:** You have a clear message from the Welsh Government.

[242] **Mr Cairns:** Yes, I think that we do.

[243] **Mike Hedges:** Could you update us on the general pace of reconfiguration, and do you have any concern that reconfiguration could bring additional pressures to UHW?

[244] **Mr Cairns:** I can comment on the south Wales programme, which is now reaching a point where we will, very shortly, be trying to form a view about what consultation has told us. I need to say that the south Wales programme is focusing on only three services, about 6% of our turnover, collectively, in south Wales. I think that it is just the start of a series of conversations that we are going to need to have about doing things very differently over the next four, five, six or seven years, going into the future. Those initial conversations are aimed at ensuring that we continue to have sustainability in a number of extremely critical services: A&E, paediatrics and obstetrics. I think that we will end the process with a plan to enable that to happen, but we then have a bigger conversation that needs to continue, which is, given the demographics and the scale of the challenge that health services around the world face, the question of what we are going to do differently over the years ahead. So, I think that the conversation does not finish when we arrive at a view about what we can do with 6% of our turnover and three services. I think that we will need to continue to have that conversation in the months and years ahead.

[245] In terms of the impact on UHW, one of the reasons why we are taking some time to evaluate what comes out of the consultation is that we do want to be sure that whatever comes out of that is deliverable. We are certainly not going to be part of a process that provides the UHW site with more demand than it can cope with.

[246] **Darren Millar:** On that note, I will bring this part of our meeting to an end. Thank you very much, Adam Cairns, for your attendance today. You will get a copy of the transcript of proceedings. If there are any matters that need to be corrected, you can draw those to our attention, and we look forward to receiving the further information that you have agreed to provide. Thank you very much indeed.

10:48

Papurau i'w Nodi
Papers to Note

[247] **Darren Millar:** Under this item, we have the minutes of our meeting on 15 October, a letter from David Sissling on the national framework for continuing NHS Healthcare, and another letter from David Sissling on the governance arrangements at Betsi Cadwaladr University Local Health Board. I will take it that those are noted.

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

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

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

[249] Does any Member object? I can see that there are no objections, so we will move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:48.
The public part of the meeting ended at 10:48.