Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 12 Tachwedd 2013
Tuesday, 12 November 2013

Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives

Jocelyn Davies	Plaid Cymru The Party of Wales
Mike Hedges	Llafur Labour
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

Helen Birtwhistle	Cyfarwyddwr, Conffederasiwn GIG Cymru Director, Welsh NHS Confederation
Kevin Flynn	Cyfarwyddwr Cyflenwi a Phrif Weithredwr GIG Cymru Director Delivery & Deputy Chief Executive of NHS Wales
Mark Jeffs	Swyddfa Archwilio Cymru Wales Audit Office
Stephen Lisle	Swyddfa Archwilio Cymru Wales Audit Office
Dr Grant Robinson	Arweinydd Clinigol ar gyfer Gofal heb ei Drefnu Clinical Lead for Unscheduled Care
David Sissling	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol/Prif Weithredwr, GIG Cymru Director General for Health & Social Services/Chief Executive, NHS Wales
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Allison Williams	Prif Weithredwr, Bwrdd Iechyd Lleol Cwm Taf Chief Executive of Cwm Taf Local Health Board

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

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

Dechreuodd y cyfarfod am 08:59.
The meeting began at 08:59.

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 to switch off their BlackBerrys, pagers and mobile phones because they can interfere with the broadcasting and the sound equipment. The National Assembly for Wales is of course a bilingual institution and we should feel free to use either English or Welsh as we see fit during the course of the meeting. If at any time there is an emergency call, the ushers will show us to the nearest appropriate exit. We have everybody here today; there are no apologies other than from the Auditor General for Wales, and I am pleased to welcome Dave Thomas, who is standing in for him today.

09:00

Cyllid Iechyd 2012-13 a Thu Hwnt: Tystiolaeth gan Gonffederasiwn GIG Cymru
Health Finances 2012-13 and Beyond: Evidence from the Welsh NHS Confederation

[2] **Darren Millar:** We move straight on to item 2 on our agenda. We are taking evidence this morning from the Welsh NHS Confederation, and it is a pleasure to welcome Helen Birtwhistle, director of the Welsh NHS Confederation, this morning, along with Allison Williams, chief executive of Cwm Taf Local Health Board. Members will recall that the Wales Audit Office published its report in July of this year, and we have already had a short briefing and taken some evidence from the Welsh Government on this subject.

[3] You are very welcome to today's meeting. Thank you ever so much for the written evidence that you have provided to us. I will start with an opening question, but feel free to have a bit of a preamble and introduce the subject and some of the points that you wanted to make in response to this, as well as answering the specific question. Tell us, Helen: what do you think the likelihood is that NHS organisations will hit their responsibility to break even at the end of this financial year?

[4] **Ms Birtwhistle:** First of all, thank you very much for inviting us. We are pleased to be here. Just as a preamble to answering that question, we welcome this report from the Wales Audit Office because we think it reinforces the huge challenges, and that is echoed in your question. It also highlights significant progress and achievements to date from the NHS in Wales; I do not think we should forget that.

[5] It is a huge challenge for health boards to break even this year, but that is what they are working towards very clearly, and they know what their responsibilities are in terms of that break-even position. The Wales Audit Office report sets out the scale of the challenge in terms of the gap that needs to be filled, and we have said before that tough choices and decisions have to be made in terms of health services in order to bridge those gaps. There are issues around short-term solutions and medium and longer term solutions. We are still very firmly proponents of transformational change in the health service, which, over time, will allow for better financial planning, better service planning, better workforce planning, and bringing those three things together around the needs of individual patients. One thing I would like to highlight in terms of the break-even requirement for health boards and trusts is that, obviously, that is an organisational responsibility, but there is a lot of work as well to very good effect that is going on collaboratively between health boards and trusts across the whole health service. Indeed, in the longer term, we have to look much more widely at our colleagues in other parts of public service and the third sector.

[6] **Darren Millar:** So, the NHS as a whole you expect will break even at the end of this financial year. The auditor general obviously identified a funding gap of around £2 million when his report was published earlier this year. What do you anticipate the current gap is between savings that are expected to be delivered and the financial requirement to break even at the year end?

[7] **Ms Birtwhistle:** The current position with health boards, as you know, is that they publish their ongoing financial position. Allison may be able to help with this as the lead chief executive on financial issues. There are gaps to be filled; there is no question about that. At the same time, health boards are working very carefully, very hard and very closely together to bridge those gaps. As I say, there is, not attention, but responsibility on individual organisations to break even. We think it is very important, and I think the south Wales programme is an indication of that—it is about health services working together across boundaries to look at the needs of patients and populations. That actually is beginning to bear fruit.

[8] **Darren Millar:** All right, but you still did not tell me what the gap is, currently.

[9] **Ms Birtwhistle:** I do not have that absolute figure, no.

[10] **Darren Millar:** Do you have any information as to what it is currently?

[11] **Ms Williams:** If we look at what the auditor general outlines in his report relating to last year, I think the figure was £220 million—that was the indicative figure. The NHS organisations have all developed plans to address that. One of the big differences going into this year has been a greater degree of certainty about the recurrent funding base for the NHS. One of the challenges previously has been the short-term planning and not having a higher degree of certainty about future years' allocations. We now have a higher degree of certainty around that. As we sit here at month 7 in the financial year—if I can take my own organisation as an example—I started the year with an identified financial gap of £37 million. We had initial savings plans that took that down to £20 million. That gap now has reduced to £8 million and we are constantly working on additional plans and initiatives to address those reductions in costs.

[12] Coming back to Helen's earlier point, what is important is that we recognise that, year on year, as we have to develop more sustainable and sophisticated plans that have to be delivered in the context of our responsibilities to deliver high-quality, safe services to patients, this cannot and should not be a systematic cost-cutting exercise, but has to be an exercise that is underpinned by transformational change. So, one of the challenges identified within the auditor general's report was the short-term nature of some of the savings plans, which, again, as an NHS we would entirely agree is not the way to be managing the finances in the long term. What we are having to do is a blend of sustainable, long-term transformational change plans that deliver financial sustainability, and short-term actions in-year.

[13] **Darren Millar:** We will come on to some of those issues in a moment. I am surprised that neither of you are able to tell me what the NHS-wide gap might be at present in this current month in terms of the projection to the year end. We know that an extra £150 million has been given by the Welsh Government in the current financial year. I assume that that helps to contribute to bring the gap down. The Government tells us that the purpose of that cash is not actually to cover the financial gap, but is more around dealing with additional pressures that it expects you to have in terms of unscheduled care. That is your understanding as well, is it? I can see you both nodding.

[14] **Ms Williams:** Yes, it is.

[15] **Darren Millar:** So that will not contribute to the gap at all. So the gap is still—.

[16] **Ms Williams:** No, it is important that we look at that in its entirety, because some of the financial challenges that the NHS is experiencing are because of the need to make

investments in these quality initiatives to deliver safe, sustainable care. So, there will be a significant impact of that investment on the financial position, because by improving some of the quality issues, we are actually able to reduce cost. So, there will be an element of that making a significant contribution, but I would not want the committee to think that that money was going into the bottom line of the NHS, because that would be abjectly wrong.

[17] **Darren Millar:** However, you are not able to tell us, in terms of the current financial position at the end of the most recent month that has been published, what the projected gap is between savings and the money that you have to spend in the current financial year.

[18] **Ms Williams:** I am not avoiding answering your question because the shift between month 6 and month 7 is going to be different, and the month 7 figures have not been published yet. The month 7 figures will reflect the additional allocation, and I think it is another four or five days before we will have that definitive figure. When those figures are published, at that stage it will be very clear the contribution that the additional money has made to the overall financial position of the NHS.

[19] **Darren Millar:** You will send us a note on that, will you not?

[20] **Ms Williams:** I am very happy to do so. What I can say is that it will have a significant impact on the gap, but what I cannot say today is exactly what that will be.

[21] **Darren Millar:** The extra £150 million was distributed on a thing called the Townsend formula. Is that the right way to distribute any additional resource coming into the Welsh NHS? If so, why? If not, why?

[22] **Ms Williams:** The Townsend formula at the moment is the only formula that we have that actually works on the basis of population share. If you sit in any community, you will argue that the formula should be worked differently. If you live in a rural community, you might argue that the rural premium component should be high; if you live in an urban community, you might argue the reverse. At the moment, it is the only formula that we have that gives a population-share distribution of that money. That is the basis upon which the money has been allocated.

[23] **Darren Millar:** I think that we know that it is on a population-share basis. The question is: is it the right way to distribute money in the NHS? Does it reflect the risks to individual organisations, and the challenge that each NHS organisation faces?

[24] **Ms Birtwhistle:** Allison has just indicated that, if you are in different areas, you would have a different view on it. Allocation is very complex. There are lots of things that come into play around needs and deprivation, rurality and urban—whatever it might be. The Townsend formula is a very set formula, which probably does not have all the nuances of those different needs. So, it is one way of making allocations; it is the way that we have, and that is what we have to deal with.

[25] In order to perhaps give some reassurance about the way that money is used once it is allocated—going back to what I was saying earlier about collaboration between different health bodies and also between different parts of the public sector—there is a significant amount of work going on with social services, for example, and that is much more able to reflect the needs of populations and individuals within those populations.

[26] **Darren Millar:** Just to get this right, because you still have not said whether you think the Townsend formula is the right formula, I would appreciate having on record whether you think it is the right formula or not. There is a health board that received much more funding than its gap was calculated to be by the Wales Audit Office as a result of this funding

distribution, and there were other health boards that still had significant gaps despite the additional resource given. Do you think that that is a satisfactory way for the Welsh Government to give additional resource to the Welsh NHS in the future?

[27] **Ms Williams:** If I may give you my personal view—

[28] **Darren Millar:** Yes. Please do.

[29] **Ms Williams:** I think that we have to have a population-based allocation formula, because this is not, at the end of the day, about organisations; it is about the people whom we serve. I think that there is a question about whether or not things have changed since the original formulae were established, and there is an opportunity to look at whether the individual component parts of a population-based allocation formula need to change to reflect population changes. However, a fair share of the allocation, based on population, is the right thing to do, and not necessarily to chase deficits.

[30] **Darren Millar:** Okay. Thank you for that. Jenny Rathbone is next.

[31] **Jenny Rathbone:** I am sure that part of the £150 million was to increase immunisations against measles and flu. Is it not an accurate assumption that that, therefore, would save money on caring for people with flu or measles?

[32] **Ms Williams:** Absolutely. This is why I referred earlier, in answer to Mr Millar's question, to reconciliation between money given for additional quality initiatives and the impact on the bottom line. We know that investing in some of these preventative measures, which themselves have a cost, has a benefit in terms of the reduced burden on acute care in the longer term. So, absolutely. Those are quality initiatives, which will have a benefit.

[33] **Jenny Rathbone:** Okay. Thank you. Could you tell us what the Welsh NHS Confederation's view is of holding NHS bodies to account for their financial performance? There was a historic culture of hospitals just spending money and assuming that they would be bailed out. Now we have a really clear directive from the Welsh Government that boards are responsible for coming in on budget, and not spending money that they do not have. What is the view of the Welsh NHS Confederation of this really clear directive? You have two NHS bodies that have, nevertheless, been given extra money, because they did not meet those requirements.

[34] **Ms Birtwhistle:** The view of the Welsh NHS Confederation is, actually, the view of our members, which is that it is quite right. I think that our members would all agree that they take full responsibility and have accountability for the way in which these resources are used. So, I think that we would be very firm about that. What we also have to recognise is that we are asking our health organisations and other public sector bodies to manage less—I know that the recent draft budget has allocated more to health, but that is against the backdrop of having an almost 10% real cut in health funding over the last four years. So, it is against the backdrop of having to manage finances, which are very important—that is what people on our boards have to be accountable for at the end of the financial year. We welcome the move to three-year planning but, nonetheless, there will still be accountability and responsibility, and that is absolutely right.

09:15

[35] It is also about priorities and balancing quality and safety. I think, in an age of austerity, that is proving a very difficult balancing act. We have to bear that in mind all the time. So, there are very clear financial accountabilities and responsibilities. The money is the money as far as the NHS is concerned, and, as far as our members are concerned, that is what

they are given and that is what they have to manage with and deal with. However, it is not as simple as balancing the books at the end of the year, as it is about priorities and deciding upon, possibly, different priorities. Allison has alluded to being able to change services, to transform services, and to do things very differently. At the moment, the financial position that we have been in, and which we are in, means that it is very difficult to reinvest and transform services, and to reinvest in new services, at the same time as having enormous pressures on the existing services, funding and finances.

[36] **Jenny Rathbone:** So, does the fact that Powys and Hywel Dda LHBs got extra brokerage funding undermine the message among your members?

[37] **Ms Birtwhistle:** I do not think that it does, because I think, as I mentioned earlier, it is about that more collaborative working and the particular needs of particular populations and health boards. Remember that we have a model of care and a model of hospitals in Wales that is very outdated and which is sucking up money. That legacy is harder for some health boards than it is for others. I think that it is important that we look at the needs of the population of Wales and the healthcare for the population of Wales across boundaries, where that is appropriate.

[38] **Jenny Rathbone:** So, Allison, given the task that boards have been given, how does that impact on the attitude of your board, and of other boards, towards meeting this financial target?

[39] **Ms Williams:** I have been a board member since 1995 and a chief executive since 2003 in various organisations. The statutory responsibility has always been something that has weighed very clearly and very heavily on the shoulders of the board. So, there is no doubt that the responsibility for quality, safety and the appropriate use of resources is very clear with boards. The challenge for us is that, in successive years of dealing with challenging financial situations, the traditional methods of finding savings within the NHS will not serve us well in the future. One of the reasons the health boards have come together, with the south Wales programme, to look at systems of redesign is that we recognise that organisations on their own cannot redesign a system, and that is because patients do not recognise organisational boundaries. So, if I am looking over the fence to my neighbours in Powys, in Hywel Dda, in Cardiff or anywhere else, we know that the interdependency and the need to completely transform our system is what will get us improved quality and a more financially sustainable position moving forward. So, I think that every individual board entirely accepts its responsibility, but I sense a growing collaborative understanding that it is system change that will deliver us better quality and sustainability, rather than organisations working on financial plans in isolation.

[40] **Jenny Rathbone:** Okay. Thank you.

[41] **Darren Millar:** We have a couple of supplementary questions, from Sandy and Aled. We will then move to Jocelyn.

[42] **Sandy Mewies:** Thank you, Chair. There seems to be a thinking in some areas that, somehow, there is a tick box for what you could expect to happen in health, wherever you are located. My question is about trying to establish where we are now. I would be quite interested to know whether you have had any early indications of the winter pressures, the unscheduled pressures, that we or you will be facing—well, we will all be facing; we all live here—in the coming months. For example, I know that there has been another measles outbreak in one area, which is being talked about today. Are there any early indications, because you never can tell if bird flu or anything else is going to come? Looking individually or across the piece, are there any early indications of the challenges that you may face that perhaps were not expected, or the challenges that you may face that you did expect, but

perhaps you expect to happen in more areas, or in a more challenging way, if you understand what I am getting at?

[43] **Ms Williams:** There are some things that unfortunately will always be unexpected, both in terms of the when and the what, but we should not be surprised, because winter happens every year. We know that the weather gets colder and we know that that has an impact, particularly on the elderly and on people with chest disease, and that it also increases the risk of heart attacks and strokes. We know that that is the case and one of the things that we do all subscribe to in the NHS is a very close weather-watching system, believe it or not, because the weather warnings can be very significant in terms of the way that we manage patients. So, for example, in Cwm Taf, for the last few years, we have had a weather-warning system whereby we alert our patients with chronic obstructive airways disease problems that there is going to be a drop in temperature and that they need to increase their medication. So, we proactively look at the things that we know we can monitor and measure and then we take action where we can appropriately to prevent the impact of that. However, we also know, for example, that post-bank holidays we get surges of activity, because families try to keep granny well and at home over Christmas and the new year and keep people going, and then in the new year, we get a surge of activity, so we plan for that. We profile our elective activity differently for the couple of weeks after Christmas so that we can maximise bed availability and staff availability for what we know is predicted demand.

[44] What has been different in the last year—and I understand that you are going to be scrutinising the unscheduled care agenda later today—is that the intensity and the integrity of the planning for this winter, based on last year's experience, has been at a level I have not experienced before in the NHS and that is very positive. It is multi-faceted, because it is about working to keep people well in the community, it is about front-door management of people when they get to hospital, but, also, very significantly, it is about working with social services colleagues to make sure that, as soon as people are ready to get out of hospital, they get out of hospital. That is a whole-system issue, and I will be quite frank with you, it is not just a winter phenomenon anymore. We had a drop in temperature last weekend and we had an increase in demand; that was entirely predictable, so we are planning on the basis of this. What we can never be absolutely sure about is that, if we do get a flu outbreak that puts another layer of demand on top of what we would already do, we have contingency measures to deal with that, but there is always a balancing act between demand and capacity. However, I think we are far more prepared going into this winter than we have been for a long time.

[45] **Sandy Mewies:** Thank you. That was very interesting.

[46] **Darren Millar:** Aled is next, then Jocelyn.

[47] **Aled Roberts:** I want to return to the point that Jenny was making. Do you not feel that there are inherent weaknesses in the system with regard to brokerage? If the moneys of those areas that are able to reconfigure services and bring perhaps costs in line with budget expectation are used to broker areas that have perhaps not been so successful in reconfiguration, does that that act as a disincentive, particularly when that board has to sell its reconfiguration plans to its local population? There may be a perception that there is a deterioration in service in that area, with savings then being used to actually support boards that are perhaps not as rigorous in their reconfiguration plans, given what you said, that the Townsend formula should follow population, not historic structures.

[48] **Ms Birtwhistle:** So, your question really is whether there are inherent weaknesses in the—

[49] **Aled Roberts:** Well, I do not think that there are many sectors where, if a local board is successful in its reconfiguration, and is able to bring its services in on cost, the end result is

that those moneys are transferred to areas where those reconfigurations may not have been as successful.

[50] **Ms Williams:** Perhaps I could start to answer that. I think that, first, we need to remember that we are a national health service in Wales, and that this is about delivering healthcare to the whole of the population in Wales. As organisations, we are acutely conscious of our individual and our collective accountability. I would hate to think that, in Wales, we lost that, because this is about the population of Wales. However, I think that, as we move in to a longer term planning scenario, to some extent, it mitigates some of that short-termism, and that year-end brokerage between organisations, which can be a disincentive—and I would recognise that. I think that the bold step that this Government is taking in moving to a three-year planning framework for the NHS actually gives much more flexibility and integrity to the longer term planning, which avoids that short-term brokerage requirement.

[51] However, I think that, collectively, the big challenge—and as I said earlier, in response to the earlier question—is the system reconfiguration. If I am sitting in one health board on my own—if I take Cwm Taf, for example—and if I reconfigure services in Cwm Taf to meet quality standards and finances, the impact that I have, if I do that in isolation, on the populations of the health boards of Powys, Aneurin Bevan, ABMU and Cardiff, could be devastating. Therefore, we cannot look at any one organisation as an island when it comes to transformational change. I do think that, in the context of austerity, and in the context of our need to drive up clinical standards, we are on the cusp of a really significant system redesign in Wales, which I am quite excited about, because I think that that gives us an opportunity to deliver a better health service. However, we will not do that if we work very much in an insular, 'This is my resource, this is my money, this is my workforce' kind of way, and we will not get the best that we can for the people of Wales.

[52] **Aled Roberts:** Are the financial management systems robust enough within the NHS in Wales? We were given evidence of one health board that did not have an agreed budget by September, which is almost six months in, where budgets had to be agreed with departments. Some of us need convincing that the financial management arrangements within the Welsh NHS are robust enough to deliver these medium to long-term plans.

[53] **Ms Williams:** Again, if I can speak for my own organisation—

[54] **Darren Millar:** Could you be very brief as we are against the clock?

[55] **Ms Williams:** I think that there is room for improvement, but I think that the important things are: ownership, the setting of early budgets, the agreement and the ownership by clinicians and managers of those budgets, the strict holding to account for delivery, having robust plans that are performance managed at a very local level within organisations, and key forecasting, so that you know exactly where you are bottom-up and top-down at any one point in time. I have a growing confidence that the system is getting much better at that, and I have a very high degree of confidence in terms of my own organisation's position.

[56] **Darren Millar:** Jocelyn has the next questions, followed by Mike.

[57] **Jocelyn Davies:** I wanted to ask about the delivery of savings. You will know that the report raises questions about the nature and the robustness of the reported savings, and you mentioned quality and safety earlier. So, how realistic do you think are the workforce savings targets by the NHS bodies, in light of Francis, and, of course, the need to ensure that we have an adequate workforce that can deliver high-quality care?

[58] **Ms Williams:** If we continue to do what we have always done, and try to do it with

fewer people, then, inevitably, and sadly, what happens is what happened in Mid Staffordshire, because you do not change the system, but you try to deliver care with fewer people. I am a nurse, and I know what it is like to work on the front line. So, if we have to reshape the workforce, there are a number of ways in which we can do it.

09:30

[59] We have to do it in an intelligent way. We have to look at the profile of the workforce, on a skills base, for the interventions that people are doing. You do not want highly paid nurses spending half their time doing administrative work. You have to construct your workforce properly to meet demand. You have to look at how you get best value out of that by efficient delivery models for services. Where you duplicate medical rotas, for example, for every additional medical rota that you have in place, that is an extra 11 doctors.

[60] So, how do you look at rationalising and avoiding duplication? When we look at 65% to 75%, depending on organisations, of the expenditure in the NHS being associated with the pay bill, it is unrealistic for us to think that we can work within the same financial envelope, delivering more and complex care without looking at the cost of the workforce. It may be about having fewer people; it may be about different types of people; it may be about terms and conditions; it may be about reducing reliance on high-cost temporary staff through reconfiguration; or, more likely, it is about all of the above. I would not advocate, under any circumstances, that we run the same number of beds with fewer nurses. However, what we may need to do is look at new models, where we have the same nurse-to-bed ratio, or even higher nurse-to-bed ratios, but we may not need the same beds in the same places in the same way.

[61] **Jocelyn Davies:** Last week, we heard from Cardiff and Vale University Local Health Board about its plans to reduce staff numbers. Do you expect other health boards to reduce staff numbers in the same way?

[62] **Ms Williams:** If you look at all of the health boards' financial plans, all of them will have a component part of that that is about reductions in the pay bill. There will be an element of that that will be about headcounts, but there will also be an element of that that is about reducing variable pay, which is the unit cost of the workforce. I think that, as we sit here, I could not give any assurances that the number of people employed in the NHS will stay the same. The reality is that we are going to have to look at different models and a different shape to our workforce in future.

[63] **Jocelyn Davies:** Does that mean that you are expecting health boards to reduce numbers in the way that Cardiff and Vale has?

[64] **Ms Williams:** I am not sure in terms of the way that it has done so, but if I take my own organisation as an example, has my headcount reduced year on year since I have been chief executive? Yes. Will it continue to reduce year on year? That is highly likely.

[65] **Jocelyn Davies:** You are no different to other health boards; even though it might be done in a slightly different way, we can expect that across the board.

[66] **Ms Williams:** Yes.

[67] **Jocelyn Davies:** NHS bodies claim to have saved £57.5 million on workforce management costs in 2012-13, and that is at the same time as staff costs and numbers have increased more than expected. Can you explain where the workforce savings came from?

[68] **Ms Williams:** If you look at individual health board reports, they will be able to give

you more details about that. Again, if I take my own organisation as an example, we have done a huge amount of benchmarking. We have looked at appropriate staffing levels, and we have used opportunities with turnover and natural wastage to realign our workforce models and numbers. We have reduced management costs where that is appropriate, and have worked with our staff and trade unions to do that.

[69] Also, where we have reconfigured, if I can give you a large example in my own area, we went through a big consultation exercise and reconfigured our mental health services. We had a 25% reduction in beds; we transferred a significant proportion of the workforce into the community; we repatriated patients from the private sector and we were able to reduce the workforce at the same time. The evidence is that there are now better outcomes for patients, there is better quality and there is a reduced workforce cost. This transformational change, rather than salami slicing, is what gives us the real benefit. However, it is brave and bold.

[70] **Jocelyn Davies:** Is that replicated across the NHS in Wales? I know that you can speak from your own experience, but today you are here to speak for the whole of the NHS. So, on the example that you have given us from your own workforce, is that replicated across the whole of the NHS?

[71] **Ms Williams:** You will find examples of that everywhere in different services and different circumstances. This is the platform on which the transformational change will be necessary, moving forward. This is where we have to work with our staff and with our public in particular, so that they understand and have confidence that these new models of care are, sometimes, not just as good as, but better than the traditional models—they are not so dependent on institutions and they are not so dependent on people in the way that our traditional models were. You will find examples of that across the whole Wales.

[72] **Darren Millar:** We have a very brief supplementary from Jenny and a very brief response, please. We will then move on to Mike and then Oscar.

[73] **Jenny Rathbone:** Adam Cairns, last week, raised the issue of pay and conditions for consultants and GPs, and said that the terms are much more advantageous for employers in England than they are in Wales. I wondered if that was a significant issue for you.

[74] **Darren Millar:** Very briefly, please.

[75] **Ms Williams:** The core terms of the GP contract are consistent across England and Wales. In terms of the consultant contract, about 10 years ago, when the new contract came in in England, Wales negotiated an amended consultant contract to try to improve recruitment and retention in Wales. We are now in discussion with all our trade unions about contract terms and conditions. That will be something that will be discussed with the British Medical Association.

[76] **Darren Millar:** Thank you for that. Mike is next and then Oscar.

[77] **Mike Hedges:** I have three questions, really. The first one is this: you talk about national health service collaboration, and every nurse in Wales is paid on the same pay grade, so why can you not have one centralised payroll system? I know that you are going to say that payroll does not cost you very much, and I will pre-empt that by telling you that the IT costs of setting it up and the capital costs associated with it are substantial. The second part of that relates to out-of-date drugs. If you are talking about collaborating, why do we have tens of millions of pounds-worth of drugs thrown away every year because they have gone out of date? If hospitals within the same board collaborated, or even if there was collaboration between wards, you might make some savings.

[78] The second question relates to waiting list initiatives. Why can we not make them cheaper? The third point is this: we talk about centralising elective surgery, why can we not do more centralisation? Not every hospital is going to provide every service to every person. Sometimes, I worry that, in Wales, we are more interested in the buildings than we are in what happens to people, and people are fighting to save hospitals that they want to fly past once they have an injury.

[79] **Ms Birtwhistle:** If I may come in there, all those questions have one simple answer—well, not a simple answer, but an overarching answer—which is about understanding, education and what Allison was referring to earlier, about giving the public confidence that the changes being made to services are the right changes that will then have the benefits of saving money where appropriate, creating efficiency savings and transforming services so that services are delivered in different ways so that we get a better outcome for individual patients. Certainly in terms of the centralisation of services, you know that that is something that the Welsh NHS Confederation and our members have been saying for a while, that is, that where certain specialist services can be centralised and resources concentrated that is better for everybody. It is better for patients, first and foremost. There is a difficulty—I completely agree with you—around buildings. We are fixated on buildings. It is what I referred to earlier, about a very outdated model of dozens of small hospitals scattered throughout Wales, which were fit for purpose in 1948 and 1960, but things have changed and they are no longer fit for purpose. So, it is a massive challenge to persuade people and to provide services that are better than what people are experiencing at the moment. I do think that, as a public, we are too accepting of services that are not of a standard that we should be demanding.

[80] **Ms Williams:** I want to come back on some of your specifics**.** We have a shared services model in NHS Wales. So, we now have a single provider for payroll and recruitment through the shared services that all the health boards are participating in. On medications, the waste in medications, interestingly, is not within hospitals. We have a very strong system of stock control. You will get very little wastage of drugs—as a result of them being out of date, for example—in our hospital system. The big challenge with waste is what is in people's kitchen cupboards at home. The big push that we have, working with primary care and community pharmacies, is to reduce the stock of drugs that people are keeping at home.

[81] **Mike Hedges:** Do you mean that if I look at your last annual report, I will see that the cost of drugs that have gone out of date in hospitals is negligible rather than in the millions?

[82] **Ms Williams:** If you look at individual organisations, you will see that the cost has reduced significantly. I could not give you a figure today for what the cost was last year off the top of my head, but the cost has reduced significantly. We keep much smaller stocks of drugs, prostheses and anything else because our supply chain is such that we do everything that we possibly can to balance having the right things available when we need them and minimising waste.

[83] **Mike Hedges:** Perhaps you could send us a note on what it was last year.

[84] **Ms Williams:** I would be very happy to do that.

[85] **Mohammad Asghar:** My question relates to financial planning and monitoring. The NHS has long talked about integrated service, workforce and financial planning, yet the reality has proved elusive. How confident are you that the three-year plans that NHS bodies are currently working up will succeed where others have been less successful?

[86] **Ms Williams:** I think that there are three component parts to this. One is the guidance that we have been working on jointly with Welsh Government officials regarding the three-

year planning framework. That gives a much tighter expectation and consistency around planning. Secondly, for the first time this year, a peer-review system has been put in place for plans. We have just gone through the first peer-review round of the three-year plans across the whole of the NHS. In fact, a big workshop is planned for next Monday where the elements of good practice in planning and the deficits in the NHS plans will be worked through with the directors of the organisations in the NHS—the people who are doing the planning. The third part is the scrutiny support that we have been getting from Government departments to look at the integrity and strength of planning.

[87] For me, the real issue is having strong service plans, because our workforce and financial plans have to arise from strong service plans that meet the need. The big debate that has to take place is about what the shape of the NHS will be going forward, where services are going to be delivered and in what way. We almost have to turn our planning framework completely on its head—we are no longer looking at financial planning as a discipline in isolation; we are looking at strong service planning to meet quality standards that also work within the resources that we have. That might sound like stating the obvious, but it is a step change in the way that clinicians in particular are involved in planning services for the future. At the end of the day, it is not the managers who spend the money—it is the clinicians on the front line who spend the money on patient care. Therefore, they have to be in the vanguard of leading high-quality service planning. This is going to be difficult because, as Mr Hedges said earlier, this is going to mean that services will be delivered in different ways in different places in the future. That is a debate that we have to have, and it must be driven by quality, not money, and by patient outcomes.

[88] **Mohammad Asghar:** What do you think about external consultants supporting financial management in NHS Wales?

[89] **Ms Williams:** That is always going to be a difficult issue. There will always be times for short interventions, when it is appropriate to get some expertise in to help people. However, we could not support the NHS in Wales being dependent on external consultancy to help us to do our business. That is not something that we would endorse or support. However, there are times when having some specialist expertise around a specific issue is the appropriate thing to do, but that has to be considered in the round, in terms of the appropriate use of public resources.

[90] **Mohammad Asghar:** What is the role of the NHS Confederation in encouraging staff and clinicians to share and act on learning from good practice that deliver cost savings?

09:45

[91] **Ms Williams:** That is something that, in pockets, we do very well, but systematically, we are not as good as we should be in the NHS. Through the Wales Audit Office, we have a system of sharing good practice that has been helpful to us. Where Wales Audit Office is picking up good practice, it is making that available to the NHS. We also have good-practice-sharing mechanisms within the NHS, but the only way that we will ever get that properly embedded is if we plan services together, across boundaries, and that that is led by clinicians. That is the journey that we are on as an NHS now.

[92] **Mohammad Asghar:** May I ask a further question?

[93] **Darren Millar:** Yes.

[94] **Mohammad Asghar:** Thank you. I attended an international physician conference in Cardiff city hall this weekend where some very interesting views were raised by so many doctors and physicians in NHS Wales. To my surprise, there are 50,000 doctors in the NHS in

the UK. The head of NHS England was in Cardiff, but not the head of NHS Wales, Mr Sissling, which I will ask him about later. A few things were mentioned very clearly. The physicians know where savings can be made, so why is the NHS not involving physicians, who have globally made great achievements in the medical field, but they are not helping the NHS here to save some funding?

[95] **Ms Birtwhistle:** I think that that is what we are doing, actually—

[96] **Mohammad Asghar:** But, you were not there.

[97] **Ms Birtwhistle:** The south Wales programme is an example of that, involving clinicians and physicians in all elements of planning. Part of that will be about using resources better and, therefore, making savings.

[98] **Darren Millar:** We have already been beaten by the clock for the session, but Sandy wants to come in with a very brief supplementary question. If you could give a brief response to that and then we will go to Julie and Aled for our final two supplementary questions.

[99] **Sandy Mewies:** I was very interested in the innovative ways that you were discussing that savings have been made by financial planning. One method that you talked about was repatriation of services, which, living in and representing a constituency, as I do, quite near to the English border, I am interested in. What do you think are the barriers to people accepting that repatriation can be an effective way of delivering cost-effective, hopefully better—or at least as good—services? What are you finding are the barriers? Are people the barriers? What is stopping that from happening? I must say that, whenever repatriation is mentioned, there are howls of anguish and complaints from various sectors.

[100] **Ms Williams:** Traditional flows can be very difficult to break down, but this is where we have to decide, as a system, if we are going to take a hard line on that and demonstrate that the quality outcomes for patients are at least as good, and more cost-effective, then we have to work with GPs and hospital doctors to make sure that that happens. We have evidence that it is happening, but we have to go harder and faster at making sure that we make best use of our resources in Wales.

[101] **Julie Morgan:** My question is to Helen about prioritisation of services and spending. How achievable are the service targets that you are working to and does the confederation think that any targets need to be changed or reduced as part of a wider reprioritisation?

[102] **Ms Birtwhistle:** Targets are important; they can play an important part and they are a useful benchmark. We have to make sure that targets are the right ones, and there are discussions about whether some of the targets that we have are the right ones, and that we are measuring process rather than outcomes for individuals and patients.

[103] **Julie Morgan:** Could you give us an example of the ones that you would like to—

[104] **Ms Birtwhistle:** I suppose that an example would be—and I am not sure whether it is a terribly good example, so Allison might be able to help me out—a four-hour waiting target in A&E that puts pressure—and I am not suggesting that people should be sitting in A&E indefinitely—to admit somebody, or often, as a default position, to admit somebody when it comes to three hours and 59 minutes, when, actually, for that individual patient, that is probably not the best route at all. So, it might be more time or different targets—you want the patient to get better quicker, and that might not be the best way. I think that, often, we are admitting people to diagnose, rather than diagnosing people to admit, and that is about the use of hospitals and hospital beds that we were talking about earlier as well.

[105] **Julie Morgan:** Is there evidence of that? Is it because of the four-hour waiting target that people are admitted, that is when they are almost reaching the four hours? Allison, have you got something to say on this?

[106] **Ms Williams:** It is unlikely with the four-hour target, but have we got any hard and fast evidence on when you get to the eight and 12-hour targets? The answer is 'no', but there is an argument that, sometimes, if somebody spends another hour or two waiting in the A&E department, you may be able to send them home. These are not people who are sitting and waiting and not involved in active care. Perhaps more fundamentally, there is a question about how, at the moment, we have only one front door and it has the name 'A&E' above it. There are certain patients, particularly the frail and elderly ones, for whom maybe the A&E front door is not the best place to take them. We are looking at having to remodel the pathways for those patients, because it is not the best place for them to be.

[107] **Julie Morgan:** What about deprioritising waiting lists?

[108] **Ms Williams:** It is a real challenge, because if you are waiting for surgery, that wait for you, personally, is a major issue, but we know that for some people waiting 26 weeks, there could be a deterioration in their clinical condition in that time, so they should not wait 26 weeks. For other types of procedures, waiting 52 weeks would not necessarily mean an absolute deterioration in people's health. So, I think that the real issue is how we put some intelligent clinical prioritisation alongside targets so that what we are doing is the best for clinical outcomes for patients as opposed to an arbitrary timescale that we are working to.

[109] **Julie Morgan:** With the targets that you are working to at the moment, have you had to deprioritise?

[110] **Ms Williams:** We will always prioritise on the basis of clinical outcomes and clinical performance, but in answer to whether I have to make a decision not to chase a particular target in response to another, the answer is 'no'. At the moment, we are trying very hard to balance all of that, as is the whole of the system, but it becomes much more challenging as the system runs hotter, particularly during the winter period.

[111] **Julie Morgan:** Finally, to the NHS Confederation, what are you doing to encourage day surgery and driving down the length of stay, because we have had evidence that some LHBs are doing that successfully? What are you doing over the whole area?

[112] **Ms Birtwhistle:** Our work as a confederation is to support our members precisely to do all those things. So, it is sharing experience, learning and best practice and making sure that that information is available to individual health boards and then, collaboratively, as we have said, we are working very closely together. We have the advantage in Wales that we can get everybody in one room, and I do not think that we should underestimate the significance that that can have in terms of being able to plan and long-term plan services. However, I also would not want to leave this room without underlining—I know that you appreciate this—how difficult it is at the moment, in a time of rising demand, an austerity budget and all the other issues that are surrounding our partners in social care and other parts of the service sector, to deliver appropriate services and improve services for the people of Wales. I think that that is—

[113] **Julie Morgan:** Just a last question to Allison, have you been able to reduce the length of stay of patients and increase the use of day surgery?

[114] **Ms Williams:** Yes, we have, and quite significantly, because there are three types of surgery: there is in-patient surgery; there is day-case surgery; and there is also what we call 23-hour, 59-minute surgery, which is for those people who need to stay in overnight, but are

out again very early the next morning, to make sure that that bed is available. We are seeing 60% of all elective surgery now being delivered through either day-case or 23-hour, 59-minute work. That is a huge cultural shift for patients and our staff, but it has huge clinical benefits.

[115] **Darren Millar:** I call on Aled for the final question.

[116] **Aled Roberts:** Rwyf am wneud un pwynt am hynny. A ydych wedi casglu data am faint o'r cleifion hynny sy'n mynd yn ôl i'r ysbyty wedi cael triniaeth? Yr ymateb i gwestiynau, rai cyfarfodydd yn ôl, oedd nad yw'r gwasanaeth iechyd yn casglu data am faint o'r cleifion hynny sy'n cael triniaethau yn ystod y dydd neu dros nos, fel rydych yn dweud yn awr. Faint ohonynt sy'n gorfod mynd yn ôl i'r ysbyty?

Aled Roberts: I want to make one point about that. Have you collected data on how many of those patients have returned to hospital after being treated? The response to some questions, at a previous meeting, was that the health service does not collect data on how many of those patients are treated during the day and how many are treated overnight, as you are saying now. How many of them have to return to hospital?

[117] **Darren Millar:** Could we have a very brief response to that?

[118] **Ms Williams:** We collect information on all patients who are readmitted to hospital within 28 days, and we analyse it to look at why that happens, because we consider anybody being readmitted within 28 days. For some of them, it would be for something entirely different, and they are excluded, but for those where it is related to the original index admission, we will look at that and at why it has happened. So, that is something that we look at quite carefully.

[119] **Aled Roberts:** Rwyf am symud i'r pwysau ariannol o ran yr ad-drefnu. Rwyf am gyfeirio at baragraff 3.18 yn adroddiad yr archwilydd cyffredinol, sy'n dweud ei bod yn aneglur a yw'r holl ad-drefnu yn fforddiadwy ac a fydd gwasanaethau yn cael eu darparu am gost is na'r ddarpariaeth bresennol. Er enghraifft, yn y gogledd, nid oes yr un o'r cynlluniau yn dangos y bydd y gost yn llai ar ôl yr ad-drefnu nag ydyw ar hyn o bryd.

Aled Roberts: I want to move on now to the financial pressures in the reconfiguration. I want to refer to paragraph 3.18 of the auditor general's report, where it says that it is unclear whether all this reorganisation is affordable and whether services will be provided for a lower cost than current provision. For example, in north Wales, none of the plans show that the cost would be less following reconfiguration than it is at present.

[120] **Ms Williams:** There are two components to the answer. One is about capital costs, and the other is about revenue cost. We know that, in the short term, reconfiguration can sometimes require capital investment so that the facilities can be put in a position where they can deal with a larger and a different type of demand than previously, and that is often a one-off cost. Having put that to one side, the revenue consequences of reconfiguration also have two dimensions to them. One is about delivering what we were delivering previously, and the other is about meeting royal college standards for delivering care. We have to separate both of those out, because, in delivering to the standards that the royal college has set out, there will be a requirement for investment, wherever those services are delivered. So, we have to understand that service reconfiguration must predominantly be driven by the need to improve quality and safety for patients, and that the financial consequences of that, though significantly important, are secondary. There is no point in doing something to save money if it causes the quality of care that we provide to deteriorate. So, the parameters that we have set within our reconfiguration are that, as a minimum, they have to be cost neutral, but there is not always the ability to save significant amounts of money. Significant amounts of money come when you start to take down estate and you take out overheads. That is when significant savings are then able to be made.

[121] **Aled Roberts:** Mae gennyf gwestiwn i'r conffederasiwn. Mae sôn yn eich papur bod rhaid cael arian trosiannol, lle bydd un gwasanaeth yn cael ei redeg ochr yn ochr â gwasanaeth arall. O ble y bydd yr arian hwnnw yn dod?

Aled Roberts: I have a question for the confederation. It is mentioned in your paper that transitional funding is required, where one service will be run alongside another. Where is that money going to come from?

[122] **Ms Williams:** It is often the barrier to some of the changes that we need to make, in terms of having an ability almost to invest to save—it is that principle. There are examples where that has worked very effectively. Sometimes, we can generate that flexibility internally, but not having that ability to have system-wide money to pump-prime change can be, not a barrier to change, but it can slow down the pace at which we could change. However, that is something that we as health boards are looking at together, because, again, if we are able to pool resources, that potentially gives us an opportunity to accelerate change.

[123] **Ms Birtwistle:** If I may, I would add that some of that will be helped by the three-year planning cycle that we talked about earlier. However, just to be under no illusion, when we talk about reconfiguration, we need to be talking about much more radical change, about stopping doing some things and about being able to disinvest in services. I think that there is still a view that the health service can change by doing more and more and by meeting all the demands placed on it head-on, but we can only do that by disinvesting in some services. That is proving to be very difficult.

[124] **Darren Millar:** On that note, we will bring to an end this particular session. Thank you, Helen Birtwhistle and Allison Williams, for your attendance today. You indicated that you would send us a further note on medicines wastage and on the month seven financial position, which would be very helpful indeed. Thank you very much.

10:00

Gofal heb ei Drefnu: Ymateb gan Lywodraeth Cymru
Unscheduled Care: Response from the Welsh Government

[125] **Darren Millar:** We welcome to the table David Sissling, director general for health and social services and chief executive of NHS Wales; Kevin Flynn, deputy chief executive of NHS Wales; and Dr Grant Robinson, clinical lead for unscheduled care for the Welsh Government. We are looking now at the topic of unscheduled care, which we decided to undertake an inquiry into following the publication of the Wales Audit Office report, 'Unscheduled Care: An Update on Progress', in September. It is fair to say that the report recognised that some progress had been made in this area, but stated that more needed to be done.

[126] We are very grateful for the written evidence that you submitted to the committee. Members have a number of questions that they want to ask, but do you want to make any opening remarks, Mr Sissling, before we go into those?

[127] **Mr Sissling:** No, we are very happy to take questions, thank you, Chair.

[128] **Darren Millar:** Okay; that is great. There has been a lot of focus and a lot of scrutiny on unscheduled care services from the National Assembly for Wales and the Welsh Government in recent times. Why do you think we have seen a long-term deterioration, albeit that there has been a slight improvement of late, in performance in some of those key areas?

[129] **Mr Sissling:** The longer-term view is a mixed one. There have been some areas

where there has been improvement or stability in performance, but also some where we would acknowledge—particularly under the circumstances last winter—where there has been some deterioriation. We are focusing our efforts on continuing the pattern of improvement that the Wales Audit Office drew attention to in the report. On many occasions, it said that there were signs of improvement during the early middle part of 2013, and we are pleased to report to the committee and, indeed, more generally, that that has continued. So, we are seeing, for example, accident and emergency departments' four-hour performance continuing at over 90%, which is the highest it has been for a couple of years; we have seen a very significant reduction in the number of 12-hour waits; ambulance transit times are improving and are at a level that is the highest it has been for some 18 months; there has been a reduction in patient handover waiting times and improvements in conveyance rates.

[130] So, the context is clearly one of increasing pressure on unscheduled care departments, and we have talked previously in this committee and others about the demographic changes and, additionally, the pressures that we had last winter, which were a combination of climatic and demographic changes. However, the positive issue to present to the committee is the improvement. We are going into the winter period with much stronger foundations and we are, we believe, better prepared.

[131] **Darren Millar:** Do you expect that you will be able to sustain the improvements in those services? Why do you think that you will be able to sustain that improvement and keep the projection in the right direction?

[132] **Mr Sissling:** A number of things have happened over recent months. First, there has been a very strong level of ministerial interest and leadership. On taking ministerial office, the Minister, Mark Drakeford, made it absolutely clear that this is one of his priorities. Secondly, chief executives have taken ownership of a very comprehensive work programme, focusing on the areas that you would expect them to focus on in terms of the models of care, looking at out-of-hospital care, matters of leadership, looking at the ambulance review, being supported by important appointments—and we have one here, Grant Robinson, who is sitting to my right, who is national lead on unscheduled care; I might ask him to offer his reflections. The other distinctive characteristic is the much greater degree of collaboration between the NHS and local authorities. So, our winter plans are now joint documents that are signed off by the NHS body, the health board and their respective local authorities, focusing on the issues that we know only they can do together. So, there has been a heightened focus and we are seeing the results of that in practice. I wonder whether it would be helpful for Dr Robinson to make some comments from his perspective.

[133] **Darren Millar:** If you could be brief. We will touch a little bit more on some of the winter pressures later on in our discussion, but I am happy to take a short contribution now, and then I will come to Jocelyn.

[134] **Dr Robinson:** I am happy to briefly mention that I have been appointed to this role. Some of you will know that I spent the last five years as a medical director, and it became clear that my attention was being drawn towards unscheduled care. So, the opportunity to work with colleagues across health and social care in Wales was exciting. There is plenty to do; people will know that these are common problems across the whole of the care system in the United Kingdom and further afield. We are working hard to get work streams in place to address the key issues, and we are working in partnership with professional organisations such as the Royal College of Physicians and the College of Emergency Medicine. I am happy to expand on that as you wish, Chair.

[135] **Darren Millar:** Mr Sissling, to what extent does the change in the financial regime help to sustain these improvements going forward?

[136] **Mr Sissling:** The announcement of the additional funding on a recurrent basis by the Minister provided more certainty for health boards to plan for the future. That has been of great assistance in looking ahead with an understanding of the money that is available this year and in the next two subsequent years. Health boards can now plan in this critical area in a way that, perhaps, they were not able to plan when the funding was provided on annual basis.

[137] **Jocelyn Davies:** You mentioned that this became a priority for the new Minister for Health and Social Services. Can we assume that it was not a priority under the old Minister?

[138] **Mr Sissling:** No, quite the opposite. It was a priority for the previous Minister—absolutely so—but the new Minister came in and made it absolutely clear, reflecting particularly on the experience of last winter, that this was an absolute priority in terms of preparation, and that he wanted to re-emphasise the attention that we gave to this area. However, there was no sense that this was a new priority.

[139] **Jocelyn Davies:** It became a greater priority.

[140] **Mr Sissling:** I think that it became a more prominent priority. I think that there was a sense of—

[141] **Jocelyn Davies:** If everything is a priority, nothing is a priority. It is like saying that everything is important, but then nothing is important. It became a greater priority.

[142] **Mr Sissling:** The Minister made it clear that there were a number of very important issues on which he wanted to see the NHS focus, with its partners, including this and service reconfiguration.

[143] **Sandy Mewies:** I want to talk about trends in unscheduled care. There has been a lot of talk about Hywel Dda Local Health Board's intention to postpone or reduce elective activity during winter, to cope with the unscheduled care demand. I have a couple of questions on this. Are we likely to see similar reductions in other areas of Wales, and if we are, is that the right way to go? I was extremely interested in hearing Allison Williams talk about the work that is going on in health boards, including her own, to predict these pressures, for example, through weather watch. I was also interested in hearing her say that the A&E door is not always the appropriate door for frail and elderly patients to enter the system. I am quite sure that there would be others as well. Do you agree with that, and, if so, is this generally recognised and what can be done about it? If they cannot go in through A&E, they have to go in some other way; they have to enter the system if they are not well through somewhere else.

[144] The previous witnesses, Helen Birtwhistle and Allison Williams, also talked about the four-hour target not always being the most supportive way to get the best results for patients who enter A&E. They suggested that, sometimes, waiting longer, monitoring better and treating and sending people home could be a better way of dealing with it. There will obviously be some cases where triage would say, 'You're dealt with straight away'. Is that something that will be looked at now? Is it good practice and will it now be shared so that we can cope with these pressures, which, as she clearly pointed out, happen every year, because winter happens every year?

[145] **Mr Sissling:** Others might like to contribute, but your question plays to the significance of good planning for the short term, the medium term and the long term. All the health boards have dedicated an enormous amount of attention to planning for this winter. They are now doing a similar exercise for the next three years. Those plans are comprehensive and they do not simply focus on hospital issues—they look at the healthcare system and are as concerned about the alternatives out of hospital as in hospital. They are

concerned about understanding demand, learning from previous years and planning on that basis. The plans at the moment indicate an ability, or a determination, to develop capacity, with more than 440 additional beds or bed equivalents for this coming winter. It is important to say 'bed equivalents', because it is not just beds in hospitals; it is also the capacity that can exist out of hospital that allows either anticipatory or diversionary care arrangements, or allows us to expedite discharge from hospital.

[146] So, the attention that has been paid by the health boards is, appropriately, on the whole healthcare system. That will link to the work that the Minister has indicated that he would want to bring to a conclusion over the coming months, which is looking at some of the measures—some of the ways that we monitor and oversee what our understanding is of good performance in the NHS. Some of those issues will take account of some of the comments that Allison and Helen shared with you earlier. Grant, do you want to talk about some of the clinical aspects?

[147] **Dr Robinson:** Yes, please. I would particularly like to pick up on the question about care for frail and elderly people. Both in Wales and beyond, we know that the demand for admissions has been driven by the increase in admissions for our oldest citizens. In Wales, we are now admitting 6% more people over the age of 85 than we were two years ago—over 10 years it is nearly 60% more. So, there have been huge increases and they are set to continue. That is a good-news story, because we are all living longer, but what has become clear—and I think that this is reflected in that question about priorities and changing priorities for the health service—is that a very medical model of care, coming through a busy A&E, is not always the best front door for an older person. We have work to do to change our whole system of care. We cannot just do that from the hospital end, as it has to be done in partnership with social care partners and with community teams.

[148] This is new territory for some of my professional colleagues. It is a challenge that they are rising to, and these are conversations that colleagues are anxious to have, as we have to learn our way into this new way of providing care. For someone who is very elderly, it may be that even a heart attack is not their biggest problem, because their biggest problem can be that they are socially isolated and dependent on other people. Getting the balance right, so that we get that red-stream care for serious conditions like heart attacks and stroke, and balancing that against more holistic care, is going to be very important for our new model of care. I think that that will see us introducing models of care that we do not have now—bespoke front doors for older people that are specifically designed to deal with their care needs. Some of that is starting to come on the ground in Wales, and some of the initiatives that health boards are putting in place are going on the ground. Our job in the programme will be to share the best practice from inside Wales and from beyond, and make sure that we spread it as rapidly as possible.

[149] **Sandy Mewies:** Could you give us a few examples of this bespoke care?

[150] **Dr Robinson:** A number of frailty, or older people's care, units are appearing across the United Kingdom. This year in Morriston Hospital, there will be a part of the front door that is specifically aimed at older people. In the health board I have just come from, namely Aneurin Bevan, we were in the middle of developing plans for this winter to improve the presence of senior care-of-the-elderly decision makers at the front door. We need to think a little more widely about who is going to do the decision making. There is certainly a role for hospital consultant colleagues, but there is also, undoubtedly, more of a role for general practitioners to work together across systems of care.

[151] Yesterday morning, I was in Singleton Hospital, visiting the acute general practice unit, where there are GPs on the ground that can take referrals from their colleagues and deal with up to a third of the cases that might have come through an accident and emergency

department. There are bits of this good practice starting to appear, and we would want to pick up the best bits and drop them around in as many places as possible. This is different from the way that we do business at the moment.

[152] **Sandy Mewies:** Another plank of the question is the reduction or postponement of elective surgery. Is it sensible? This is the argument, is it not? Is it sensible and something that you should be doing, or is it not sensible?

10:15

[153] **Mr Sissling:** I think that all health boards have been tasked with preparing for winter and anticipating additional demand for non-elective care. That is an entirely appropriate task to ask them to undertake, and we would ask them to be thorough. In doing so, they need to look at the totality of the capacity that is available to them and to make sure, at any point, that they can respond to the needs of the most urgently clinically ill patients, which would tend to be those that are coming through the non-elective route. So, the attention they are given to making sure, at any point, that they have the right balance and the right balance to flex into elective capacity, if that is necessary, is entirely appropriate. I would have to say though that it is not just a question of saying there is a fixed capacity; as I said, the health boards are planning to significantly increase their capacity over coming months so they can utilise that to meet the needs of non-elective, unscheduled care patients.

[154] **Sandy Mewies:** Okay. A new national programme board was created in 2012, with an additional £10 million made available for unscheduled care services. What is involved in that? What is new about it? Is it going to be better? Is there a suggestion that it did not work before and that this is going to be better, and if it is going to be better or different, what is the difference responding to and how will the performance be monitored and evaluated?

[155] **Mr Sissling:** I think I would have to say that it is going to be better, but I do not think that that is a critical comment on the previous arrangements. It has evolved from the previous arrangements and it builds on the success or the impact of those, which I think was very important. There are some significant differences though, one of the most significant being the ownership of the NHS leadership. This is led by two chief executives, Andrew Goodall and Elwyn Price-Morris, who are leading it on behalf of their colleagues and on behalf of the NHS, with Welsh Government there in a supportive sense to make sure things are on track. We have also developed, as we can see from Grant, a much clearer national clinical leadership with appropriate support. We have created a team that can support Grant and other colleagues in this work, so this now has a bit more horsepower behind it, I suppose it is fair to say. It is very clear that it is working with focus; it is not spreading its attention in every direction. It has identified five themes that it will be particularly focusing on. It started with too many priorities—shades of an earlier question—but it now has five very clear areas that it is focusing on where it will hold it to account and we will hold it to account for delivery.

[156] What is particularly encouraging is the extent to which we are getting local authority buy-in and participation into some of the work programmes. So, it is development, and there are an awful lot of positive signs. If you look at the good planning, the signs of performance improving, and if we look at these kind of arrangements, those are the things that would give us some sense of confidence, while acknowledging clearly that the challenges will be very intense, and, no doubt, there will be times of challenge and difficulty over the coming months.

[157] **Sandy Mewies:** Finally, can you give us an idea of how the additional £10 million has been spent and how that has been evaluated? Chair, I would like to ask for a list of the five priorities that have just been outlined to be sent to us. I would be very interested to hear from Grant Robinson about some of the things that you have been talking about for frail, elderly patients who should not be going through the main accident and emergency route, and

some of the projects that you know about; I would like to see a list of those.

[158] **Darren Millar:** I will just remind Members that we also have Baroness Ilora Finlay coming to give evidence to the committee, which will give us an opportunity to look at the care of the elderly, frail, infirm et cetera.

[159] **Sandy Mewies:** These are definite, specific projects I would like to hear about.

[160] **Darren Millar:** They are and, of course, a note from Grant would help us with that particular evidence session as well in terms of what is already taking place, prior to Ilora coming.

[161] **Aled Roberts:** May I ask what information will be made available locally so that people understand that that is going to happen to them?

[162] **Darren Millar:** I am sure that that is being noted right now. Mike wants to come in very briefly before I come across to Oscar.

[163] **Mike Hedges:** Dr Robinson, you said that a third of patients who turned up actually needed to see a GP rather than needing more serious interventions. Were they there because they could not get to see their own GP? Mr Sissling, are you going to promote having an out-of-hours GP service alongside accident and emergency, as it is in Morriston, across Wales? The third arm of this is that if all GP surgeries went out to visit patients in their home, would that not reduce the number of people ending up in accident and emergency?

[164] **Dr Robinson:** On the first question, I would encourage anyone who is interested to visit the Swansea acute GP website, where Chris John's team have their services laid out. Just to qualify the one-in-three figure, they are taking calls from their fellow GPs, and they are able to deal with about a third of those. Therefore, one in three people who a GP might have sent in to a medical team can be dealt with by the acute GP team. I do not think that there is any doubt that improving access to GPs is going to be helpful in managing demand across the whole system. There are different streams of care, and one helpful thing to hold in your head is what we are dealing with. There are some conditions, which you might call red-stream conditions, such as heart attacks, strokes, or broken hips, where people are always going to need to come into hospital, and the conversation is going to be fairly quick. I think that there are an increasing number of conditions—some of which we may have treated in hospital before, such as blood clots, and so on—where there are opportunities to convert that into ambulatory care. I think that we probably need to do more of that, so there is an area of opportunity there. Older people need a slightly different approach, and, again, general practitioners are definitely part of the jigsaw that you need to put in place to provide best care there. Therefore, if the first response—which will often come from a GP or their team—can be made as timely and as appropriately as possible, and, importantly, if it fits into a directory of service in that local area, that will make us as effective as we can be across the whole system.

[165] **Mr Sissling:** To specifically answer your question, there are several sites where there is a co-location of the out-of-hours service with the hospital-based emergency services. We want to develop that further, so the answer is that, yes, we will be promoting that. Moreover, we want more than co-location; we want integrated working between the professionals that are involved. Simply being on the same site is progress, but we want to ensure that those who are involved in the out-of-hours service and those who are involved in hospital-based services see themselves, in a sense, as part of a single service.

[166] **Mike Hedges:** Like Morriston.

[167] **Sandy Mewies:** What about the £10 million spend?

[168] **Darren Millar:** There is this issue of the £10 million spend that Sandy referred to in her question and how you are ensuring that that is being used effectively.

[169] **Mr Sissling:** The £10 million relates to the money that was mentioned in the report, which was in 2012-13. That was made available on a non-recurrent basis at that point, which—just as a side note—means that the fact that the money is now being made recurrently means that it can be invested in a different way. So, this was made non-recurrently, and it was used last winter to support a range of initiatives, including surge capacity, and the resources within the ambulance service, which received a portion of that to allow it to respond to the pressures that it was experiencing. Therefore, it was used well, but the fact that we now have recurrent funding available means that we can use it in a more long-term, sustainable sense.

[170] **Darren Millar:** The other issue, which you did not fully answer, was the Hywel Dda situation. Obviously, a decision has been made to postpone a certain volume and certain types of elective surgery. You mentioned that winter plans are being drawn up, across Wales, obviously. Does the Welsh Government sign those off?

[171] **Mr Sissling:** We ensure that we have a good look at them, yes; we will raise any concerns about them, so, in a sense, yes, we are ensuring that they are satisfactory.

[172] **Darren Millar:** Are you content with Hywel Dda's decision to postpone a significant volume of elective surgery?

[173] **Mr Sissling:** In terms of the factual position, Hywel Dda has not taken a decision to postpone—it is exploring several options, one of which looks at some reduction in some elective capacity, for a period of time. That is subject to wide processes of engagement and consultation, internally and externally. It will be coming towards a decision over the next few weeks with its board—I think that it is on the twenty-eighth of this month. So, this is not a decision that is taken; it is an option that is being explored. We support it in exploring options and in engaging with staff and other organisations that have an interest, to ensure that its plans are appropriate for the winter.

[174] **Darren Millar:** I accept that Hywel Dda has rowed back from its announcement that it was going to postpone some non-urgent elective surgery, but it did make an announcement—although it may have rowed back from it at the moment. However, what discussions did it have with you, prior to its initial announcement, which it may now be reflecting on, when it said that it was going to stop that elective surgery? What discussions did it have with you before that became public knowledge in the media?

[175] **Mr Sissling:** As I say, I am not aware of an announcement that it made that it was doing that. Our understanding was always that it would be engaging on these proposals, as part of a planning process for winter. So, we think that it is entirely appropriate for them to explore options for the future for the winter period.

[176] **Darren Millar:** May I just clarify this? Before 21 October 2013, when the health board made an announcement that it was going to withdraw and postpone a certain volume of elective surgery, what discussions did it have with the Welsh Government?

[177] **Mr Sissling:** It had shared with us its winter plan, which had some reference to the need to manage elective and non-elective activity together. That is something that a number of health boards would be saying that they would be exploring. Then, it made its decision to move to this period of engagement and consultation.

[178] **Darren Millar:** Just to clarify, every health board has signed off its winter plan, but this health board has not yet made a decision on how it is going to deal with the winter, because it is having a board meeting on 28 November. So, you have signed off a winter plan on the basis of a decision being made; is that right? I am a bit confused.

[179] **Mr Flynn:** The winter planning process is a cyclical process that we have been working through. Part of the discussions has been about us stress-testing their plans, to a degree. However, the process of sign-off of winter plans in most cases by health boards is undertaken during November, because it goes to the November boards. The formal sign-off of that will be during November.

[180] **Darren Millar:** So, we do not have formal winter plans in place until part way through the winter. Is that what you are suggesting, Mr Flynn?

[181] **Mr Flynn:** No; we have winter plans, but they need to be formally signed off as part of the formal sign-off process.

[182] **Darren Millar:** So, for clarity's sake, the decision of the board to sign these things off is just a rubber stamp, is it?

[183] **Mr Flynn:** No; I would not say that.

[184] **Darren Millar:** So, on 28 November, the health board will be signing off its winter plan, which you anticipate will have this reduction in carrying out non-elective surgery; is that right?

[185] **Mr Sissling:** I am not sure that we would anticipate that. We will obviously be in discussion with the board over the next couple of weeks as its process of engagement and consultation reaches a conclusion. Some health boards have signed off their plans, and I will put those into the public domain. Others are signing off their plans this month—they will all be signed off this month. It will be at that point that they are formally signed off and then go into the public domain.

[186] I think that it is important to say that winter planning has been a process that started a number of months ago. It is a process whereby the health boards had to look at the demand on their services and at their experience of previous years. They had to share good practice and put in place some actions that some of them have already mobilised, as I explained earlier, in terms of developing capacity or recruiting additional staff to ensure that they are in a position to go into winter in a very secure way to allow them to meet the demands of the next few months.

[187] **Aled Roberts:** If the formal decision has not been made, and if options are still being considered, why are letters being sent to patients indicating that the decision has already been taken?

[188] **Mr Sissling:** I have not seen any letters of that nature. I would be very interested to see those letters.

[189] **Darren Millar:** Do you have access to those letters, Aled?

[190] **Aled Roberts:** I have not, but I think that other Assembly Members may have.

[191] **Mr Sissling:** As I say, I would be very happy to look at them. The position confirmed and reconfirmed by the health board is that this is a process of exploring options and that it is discussing them with, of course, its orthopaedic surgeons, other members of staff and other

interested parties before it comes to a decision later this month.

[192] **Jocelyn Davies:** If this is part of a normal planning process, why was it a news story? Why do you imagine that this was a news story if it is just a normal planning process that all of the other health boards are going through, and that it is just normal yearly winter planning?

[193] **Mr Sissling:** I could not really comment on why it became a news story. I think that it is quite appropriate that there is a level of public interest in health boards' plans, but I could not comment on why it became a news story.

[194] **Darren Millar:** We are having a debate this afternoon on winter planning in the NHS, which seems to be premature, given that the plans are not signed off.

[195] **Mr Sissling:** I think that that would be the wrong impression. The plans have been subject to a huge amount of attention—

[196] **Darren Millar:** However, they are not signed off, Mr Sissling—that is what you have just told us.

[197] **Mr Sissling:** Some of the boards are signing them off this month, to allow them to take advantage of all of the work that has been undertaken over previous months. In some cases, elements of the plans have already been agreed and actioned. This is the final sign-off of a very long, significant and important process.

10:30

[198] **Mohammad Asghar:** Before I ask David my question, I will say that I attended a two-day international physicians' conference at city hall in Cardiff. Our First Minister attended and made a speech and the Minister for Health and Social Services gave a speech, and there was some marvellous information that came up there from big, global physicians, consultants and doctors from America, India, Australia and so on, and I never saw you there. I was surprised by that. One speech that a doctor from this country made—by the way, NHS England was also there—was about great savings that can be achieved if you consult physicians. The consultants and doctors know better than many of those who are not actively doing the work of the day-to-day running of the NHS. That was one of the points. So, in future, if anything happens, I would be grateful if your department would attend those sorts of conferences. It was a two-day event in city hall and in St David's Hotel. That is one question, or, rather, information. The question—

[199] **Darren Millar:** Shall we give them an opportunity to respond? I think that Dr Robinson was itching to respond there.

[200] **Dr Robinson:** It was just to say that I was there. [*Laughter.*]

[201] **Mohammad Asghar:** I meant David. I did not see David; he is the head of NHS Wales. The head of NHS England was there.

[202] **Dr Robinson:** Just to respond to you, it was a great conference. I did not get to see as much of it as I wanted to, because I had to escort the First Minister and the Minister for Health and Social Services around. To respond to the question about involving doctors, there is a will to do that and, certainly, an important part of the unscheduled care programme now is to build those clinical conversations and make sure that they are very much aligned with the management processes that are going on.

[203] **Mohammad Asghar:** The substantial amount of money that can be saved was

mentioned, but I will not mention it. I would rather move on to my question and—

[204] **Mr Sissling:** Just to say, it is a conference that I attended the previous year and, indeed, spoke at. For one or two reasons that I will not go into here, I was unable to attend this year, but I know that it is a good conference and, but for that, I would have attended and will attend future ones. So, I understand your point.

[205] **Mohammad Asghar:** Could you provide more details on how the funding of £123.5 million of unscheduled care described in the Minister's statement on the 2014-15 budget will be spent? How will the Welsh Government ensure that this money has a sustainable impact on the unscheduled care system for NHS Wales?

[206] **Mr Sissling:** The funding made available to the NHS is—I think that is it fair to say—intended to support, and will support, two important areas. One is in respect of the plans that the health boards prepared for this year, which they were tasked to support in a way that provided them with appropriate capacity, appropriate resources and appropriate new models of care to meet the challenges of this year, which we anticipated—there are shades of what we discussed earlier. So, some of this will be, for example, to support that additional capacity, which I mentioned earlier, to meet the increase in demand over the next few months.

[207] However, it is also important to say, because you used the word 'sustainable' in this, that it is not just simply an injection of short-term funding to meet today's problems with today's solutions; it is thinking about tomorrow. So, there will be investment in a number of areas—for example, in clinical decision units and new models of care, for advanced practitioners and in extended working arrangements. We are not in a position to say that we are moving to 24/7 working, but we are looking at, and will be supporting, initiatives—some of these are happening—to extend the working days of key clinicians, particularly senior doctors. We are also looking at new roles to make sure that the workforce of the future is one that can meet the demands of the future. So, the funding will be to make sure that we are prepared for this year, but it will also be facilitating and stimulating significant sustainable change for the future.

[208] **Julie Morgan:** How can you ensure us that, in non-emergency departments that are under severe pressure, good-quality standards of care are maintained and that we do not have examples of people being on trollies all night, or being treated in corridors, of which, I know there have been quite a few examples?

[209] **Mr Sissling:** I will start and perhaps ask Dr Robinson to come in. The starting point has to be good planning. Hopefully, today, we have described processes of planning that are thorough and attempt to understand the demand that we face. The planning has to anticipate that, at times, there will be particular spikes of pressure. That is the real world. We know that there will be occasional days over coming months when there will be pressures on the service, and we have to be in a position to respond to that.

[210] What we are doing is paying particular and increasing attention to the outcomes of care, so we are focusing on the outcomes of stroke care, cardiac attacks and fractured neck of femur. There is a big focus, increasingly, on patient experience. From this month, we will be reporting in a much more thorough way on patient experience. We have introduced a comprehensive and standardised arrangement across the whole of Wales so that we can understand patient experience. We also have escalation arrangements in place, so, when the pressure gets on within organisations and between organisations, they can make the right responses to increase capacity or to adopt an approach that is based on geography that goes beyond a single organisation. So, there are a number of different areas in which we are working; perhaps, Grant, you could say a couple of things about that.

[211] **Dr Robinson:** Sure. So, also reflecting on my previous experience as a medical director, being involved on the ground, I do not think that there is any doubt that unscheduled care services are increasingly focused on by organisations or that the pressure on them causes issues. The obvious thing to say is that dealing with the timeliness of care—making sure that ambulances are not delayed and that there are not long waits in A&E—is an important part of all that. On top of that, there are things that David started alluding to around increasing the focus on patient experience, so that the fundamentals of care tool that is used by nurses to ensure standards of care is being developed to look more precisely at unscheduled care and the experience of patients in emergency departments. There are specific safety measures in place; we monitor, for instance, rates of deaths from key unscheduled care conditions like heart attacks, strokes and fractured neck of femur and, in fact, from this year, all that information is available for every health board on the internet, as part of the mylocalhealthservice initiative. There is a hard side to that, but there is also a soft side, which involves an on-the-ground presence from senior members of the team. As a medical director, I used to have a presence in my emergency departments, and I know that many of my colleagues take the same approach.

[212] Going back to the theme that came up in Sandy's question, earlier on, about older people, I think that assuring standards of care, particularly for older people, who are, often, the most affected when the system is pressurised and there are delays in care, is very important. Again, I know that there is a lot of soft stuff going on on the ground to make sure that older people get extra care and attention when they are placed in difficult positions and on the quality of their care. So, we make sure that they are regularly offered food and water and that they are not left on a hard trolley. All those things are important as well.

[213] **Julie Morgan:** So, from what David and you said, there will be more standardised information available in the future about the experience in A&E and how you can address it.

[214] **Mr Sissling:** Very much so. One of the short-term objectives is to have a dashboard—a set of information indicators—that will cover all the information that Grant has described and to do that, as much as we can, on a real-time basis. We do not want to be working a month in arrears; we want to know about today's issues today, because they merit that level of immediacy and attention. So, we have already constructed the various different fields in this dashboard and are now working through the technical requirements to introduce it as soon as possible.

[215] **Julie Morgan:** You mentioned that when emergency departments are under pressure, it is possible to work with another emergency department. How often does that happen? That is obviously quite distressing to the patient as well, if they have to go to one hospital and then be sent on to another.

[216] **Mr Sissling:** The process that we oversee is that, on a daily basis, there are discussions, as the winter proceeds, about the pressures being experienced and the responsive action. It would be by exception rather than the first port of call for us to begin to move from the normal patient pathways into their local hospital. It would be something that would be a reflection of the system being under very significant pressure. So, it is not something that would be done routinely, for the reasons that you have described. It is much more satisfactory for patients to be admitted, if that is necessary, or admitted for an initial diagnosis into the local hospital.

[217] **Julie Morgan:** So, do you build a path for that? Are you able to say how often that happens?

[218] **Mr Sissling:** How often—I am sorry, could you clarify that?

[219] **Julie Morgan:** How often are patients taken to a hospital other than the one that they would naturally go to? Do you have that information?

[220] **Mr Sissling:** We would have that information, I think, in terms of the diversion of the ambulance service.

[221] **Julie Morgan:** I would be interested in it, if we could possibly have that information.

[222] **Mr Sissling:** Yes, absolutely.

[223] **Julie Morgan:** Thank you.

[224] **Jocelyn Davies:** Just for clarification, if somebody had been admitted to hospital, the dashboard would count if they had a bed, it would count if they were treated on a trolley, it would count if they were treated in a chair in the waiting room; it would count that sort of stuff in terms of the qualitative things that you mentioned about patient experience. It would tell us the numbers in relation to those things.

[225] **Mr Sissling:** Yes, at an aggregate level, but then, obviously, it is built up from a local hospital level. So, from our point of view, we want to see the delays in the system, and we want to see issues as frequently as available about reported patient experience and patient outcomes. I think that it is a really important area of development that we can, of course, observe the experience of our system and the experience of patients based on observation, but we also need to get the information, and that is an area of real investment for us at the moment.

[226] **Darren Millar:** Kevin, you wanted to add something.

[227] **Mr Flynn:** I just wanted to clarify something. We actually do a lot of this already, because that is what the daily phone calls are about. The health boards are swapping all that information, so that we all have an understanding of what the state of the system is at any point in time. What the dashboard is trying to do is to regularise that so that, instead of it being swapped verbally via phone calls, it will be going up on screens. Some of that information is already on screens—all ambulance-related performance across Wales is real-time information, and that is available on screens as we are having those conversations. It is a growing system, and what we are trying to do is to fuse more and more of those data to make more of it routine than is the case at the moment, swapped verbally.

[228] **Darren Millar:** Jocelyn.

[229] **Jocelyn Davies:** My questions, Chair; do you want me to go to them?

[230] **Darren Millar:** Yes, please.

[231] **Jocelyn Davies:** Just looking at trying to manage demand, you will know that NHS Direct in England is going to cease, so it will be interesting to know what is going to happen in Wales. You already know from the auditor general's reports that demand is growing, but I am afraid that there are issues around performance, high sickness-absence rates and decreases in staffing levels. Will you tell us what you are doing about that, and is the service going to continue?

[232] **Mr Sissling:** We have not made the decision that has been taken in England to in any way cease NHS Direct. We see it as an important part of the unscheduled care system in terms of the health advice and information it provides to individuals who want to take advantage of it. The fact that it is being used to an increasing extent is, we think, good news,

and we think that that reflects well on the publicity that is being given to it and on the impact of the services. In the more medium term, as we look to the future and we consider the 111 service, clearly, it will be an ingredient in our thinking in that, but we want to build on all the good of NHS Direct; we do not see it as anything other than that in our future planning.

[233] **Jocelyn Davies:** You will see that the report says that NHS Direct Wales has not played a central role in the unscheduled care system, but you have just said that it has an important role. Is it one of those that are important, but not 'the' important one, or a priority but not the top priority?

[234] **Mr Sissling:** If we move back from where we will get to, which is—

[235] **Jocelyn Davies:** Or do you intend to make it essential?

[236] **Mr Sissling:** The objective to have 111, or a similar simple telephone number, that goes along 999, so that those people who require a level of support that is not, at its most extreme, one that requires a blue-light ambulance, is such a compelling and necessary development. So, that is the game plan; that is where we want to get to, and that is associated with all of NHS Direct, but it will have a much better directory of services and it will be a much more comprehensive service. That is where we need to get to: we need to learn from the experiences of what has happened in other parts of the UK, which have been variable and mixed. Our plan is to introduce this in 2015, and we want to make sure that we have a 111 service that meets the bill in terms of NHS Direct plus. At that point, I think that it will be—I am not sure what the word for it is; it may be important, significant, or a very, very central part—

[237] **Jocelyn Davies:** Will it play a central role?

[238] **Mr Sissling:** I think that it has to. There has to be the vision, and that is what we will be driving it to do. However, it will only be realised if it is able to fulfil that particular objective and it has the right ingredients in terms of resources. Ultimately, it is the response that members of the public get when they pick up the phone to it.

[239] **Jocelyn Davies:** Okay. You will see from the report that the auditor general makes comments on the Choose Well campaign, saying that it has had only a minimum impact. Obviously, we would like to know what is being done to rectify that. It also mentions that there are some key elements of good practice in social marketing that are not being followed in terms of Choose Well, so perhaps you would explain that. Perhaps we could have a note on the cost and on whether there will be an evaluation, and so on.

10:45

[240] **Mr Sissling:** I will work back through the questions. There will be an evaluation. I am very happy to provide the cost information; we have that. We have taken advantage of the advice from the Wales Audit Office. We have already had a workshop that looked at the social marketing techniques—good advice. It used the mindspace methodology. Do not ask me what that means, but we have used it and that has been productive to health boards. We are looking, as you would expect, with real rigour at the impact of Choose Well. We are encouraged, for example, by the 240% increase in web hits for the NHS Direct website, which is attributable—certainly from the NHS's point of view—to a significant extent to Choose Well. Having said that, we acknowledge that there is more to do with Choose Well. We take on board the comments and the recommendations that we probably need to up our game. We are beginning to do that. It will be a mixture of national and local, and we will make sure that each health board has its own plan to take advantage of it. We see potential unfulfilled and it will be an ingredient in the future of the way in which the issue of

developing among the public a greater awareness of options at the earliest possible stage, and supporting that through good alternative models of care has to be the way forward.

[241] **Jocelyn Davies:** So, there have been 240 hits; that is not many, is it?

[242] **Mr Sissling:** There has been a 240% increase in hits on the NHS Direct website.

[243] **Jocelyn Davies:** Yes, but how many is that? If there were not many before, then a 240% increase is still not many.

[244] **Mr Sissling:** I could give you numbers—

[245] **Jocelyn Davies:** When you send us the note on the costs and so on, could you add that information?

[246] **Mr Sissling:** Yes, we are happy to do that and show you the costs and so on, in order hopefully to provide some assurance that this is having a positive impact in terms of hits on NHS Direct, which are significant in number on its website. It is very significant.

[247] **Mr Flynn:** It is 740,000 a month.

[248] **Jocelyn Davies:** It is 740,000 a month. That is not one person on it a lot, is it? [*Laughter*.]

[249] **Mr Flynn:** Hopefully not.

[250] **Darren Millar:** I would just like to say to Members that I am very conscious of the time, but it has been important that we have extended our sessions this morning. We will continue to ask some questions for a few moments, but I suggest that we pause on part 3 of the areas of questioning and that we invite the Welsh Government to come back at a future meeting to discuss the primary care issues and the 111 issue in a little more detail. I will take a brief supplementary question from Julie, and then we will move on to Mike and Jenny.

[251] **Julie Morgan:** My supplementary question is about the 111 service that you mentioned. Will you clarify how that relates to NHS Direct? Would you prefer to have that in writing, Chair?

[252] **Darren Millar:** We will look at that in more detail in our next evidence session with you, if that is okay, in terms of the 111 service and the primary care angle of things. However, in advance of that, we will ask you, via the clerks, for a note on your thoughts to date, if that is okay, Julie.

[253] **Julie Morgan:** Yes, that is fine.

[254] **Mike Hedges:** Paragraphs 2.34 to 2.40 of the auditor general's report highlighted the complicated medical recruitment problems facing emergency departments in Wales. Paragraph 2.37 states that no emergency department has a sufficient number of consultants to meet the College of Emergency Medicine's guidelines, and paragraph 2.39 shows that no department meets the college's guidelines on the hours of shop-floor cover from consultants. How will that be resolved, and when?

[255] **Dr Robinson:** The first thing to say is that it is unlikely, either in Wales or beyond, looking at emergency department care, that we will get anywhere near close to the College of Emergency Medicine's aspirations unless we reorganise services to provide those red-stream, high-end services in fewer places in future. That is a conversation that is not just going on in

Wales, but is going on generally. Having said that, there has been a significant increase: since 2009, the number of A&E consultants has gone up by 50%. That is one of the biggest expansions of the consultant workforce anywhere. On the number of sites we have, that does not get you close, but, at some of the sites, like UHW and Wrexham, you are getting close to the pod of 10 that you need to have to offer 100 hours of care across the week. That is over seven days and, while it might not be overnight every day, it certainly provides cover into the evening as well. We know that, for that red-stream care, that kind of senior cover is very important to delivering it effectively. Some of you may have heard my colleague from Wrexham, who got a bit of airtime on Radio 4, talking about their experience of working with their senior colleagues in Wrexham to deliver that. That is what we would want to deliver for that part of care.

[256] The very obvious question that follows on from that is: what do you do everywhere? There are other sorts of front doors: the sorts of front doors that we are talking about for older people are the GP acute units that will be running as part of the jigsaw of care alongside those. The short answer to your question is that you need service reconfiguration. There has been a significant increase in the number of consultants, but we are not where we need to be. To recruit and retain them, there is no doubt that—and some of you will have seen the *Western Mail* today—we need to improve conditions of work. That is about getting them working in a team, in a place where they can do their best work, so that they are not constantly exhausted, and that does involve a number of improvements—yes, a few more feet on the ground, but also using them a bit differently.

[257] **Jenny Rathbone:** Another key aspect of reducing blockages in A&E is not just the numbers of consultants in emergency medicine, but having prompt initial senior clinician assessment, access to diagnostics and specialist medical opinion. The auditor general's report says that there are continued problems in relation to in-patient specialities providing time and support for emergency departments. I wonder whether you can tell us what is happening to ensure that the best is being mirrored by the laggers.

[258] **Dr Robinson:** I am happy to take that. There is some change, but not enough. So, in most health boards, you will find increasing levels of senior cover—you will find people going around at the weekends, whereas a few years ago they might not have done. There are still some examples of ward rounds just happening two or three times a week; that is not enough. I think that for acute hospital in-patient care, we need to move ourselves into a system of care that runs across seven days—again, there is a wider national conversation about this. There is good practice, but there is more to do. I am very anxious that we do build on the best of what we have at the moment, but I think that part of that will be specialist colleagues working differently. Part of it also is getting the skill mix right, so that some decision making that can be done by nurses, by general practitioner colleagues, by frailty assessment units or whatever can be running alongside, so that you have a clear picture of how people are working together. Whatever your problem is, whether it is a primary care-type problem or you are an older person who has some of the problems that come along with old age, getting rapid access to someone who can figure out what needs to happen to you, and make sure that it happens, is important and is a bit different from what sometimes happens at the moment—sometimes we warehouse people until someone who can make that decision comes along to see them. We need to get away from that warehouse way of working. We are beginning to do that, but that needs to accelerate now and move into getting the definitive decision made at the earliest possible opportunity.

[259] **Jenny Rathbone:** Another example of good practice seems to be in Cwm Taf, where the ward sisters visit the emergency department first thing in the morning so that they can see what is happening and understand the pressures. There is also the idea of an elastic ward policy, so that if it has been decided that a patient needs to go to women's surgical, she can be transferred there even if the ward bed is not actually available at that time.

[260] **Dr Robinson:** Yes, I agree with that. It is also about senior specialist doctors coming down to A&E to pull out early in the morning. I know that we were doing that in Aneurin Bevan and I know that they have done it in Cardiff as well, which has been part of the story about reducing the length of stay for medical specialities in Cardiff, which is how they managed to get their 12-hour waits down so quickly. That again is good practice and I agree with you that that needs to be happening everywhere now.

[261] **Jenny Rathbone:** Okay, thank you. I will just move on to the ambulance service. That is obviously another key tool in ensuring that the right people are turning up in A&E. There seem to be ongoing delays in ensuring that paramedics are being skilled up, so that they can assess and refer patients who may not need A&E. I think that some work is being done on reducing admissions in relation to things like asthma and ensuring that there are other places where people can be taken if they need to be moved from home. Could you comment on the slow progress in implementing the ambulance review and up-skilling paramedics?

[262] **Mr Flynn:** May I just comment on the point about the alternative pathways? There has been work done around a range of alternative pathways—the ones that you describe—and, where there are alternative routes that the ambulance service can take, they are in place. That was piloted originally in ABMU health board and has now been extended to, I believe, six of the seven health boards, with the seventh moving in that direction quite quickly. So, actually, it is moving along and it has probably moved on quite a bit since the WAO report in that specific area.

[263] **Mr Sissling:** May I just give a number to support that? The analysis that we have, looking at September to September—it is virtually up to date—shows that something in the order of 2,880 patients were referred to these alternative pathways, be it for falls, musculoskeletal difficulties or chronic obstructive pulmonary disease. So, this is significant. We are also seeing the impact of the advanced practitioners and we have more advanced practitioners, so we are investing in further training. It takes a number of years for the training to be completed, so there is a little bit of a time lag, but 50% of patients treated by the advanced practitioners were treated at home or at the scene of their illness. So, there is impact and it is increasingly at scale, so the investment in the new roles will continue and the ambulance service is doing that with real determination. The question about pace is one that we are very conscious of; we are beginning to see the impact and we will continue to support that in the future.

[264] **Jenny Rathbone:** Finally, on what was raised by Cwm Taf—the idea of ringing up people who are at risk of COPD when it gets cold and advising those people to increase their medication as a preventative measure—how widespread is that sort of initiative?

[265] **Mr Sissling:** It is not as widespread as we would want it to be. Clearly, however, the whole spirit and intent of our new national arrangement is to have rapid transmission from good practice identified locally to good practice being taken up nationally. That is exactly the kind of thing that we are thinking of. We find increasingly some fantastic practice locally. All health boards have practice that they are very proud of and that is obviously having impact. So, the new arrangements are ones to challenge perhaps the history, where they were contained locally, and issues such as that are very rapidly identified and then promoted and adopted nationally.

[266] **Jocelyn Davies:** So, when—

[267] **Darren Millar:** Wait a second. I am terribly sorry, but the clock has absolutely beaten us. I know that some Members had other questions that they wanted to ask and we will collate those with the clerks and make sure that they are put to the Welsh Government in a

paper before the next evidence session that we have with the Welsh Government on this particular issue, if that is okay. David Sissling, Kevin Flynn and Grant Robinson, thank you for your attendance today. You will obviously get a copy of the transcript of today's proceedings so that you can correct any factual inaccuracies.

10:58

Papurau i'w Nodi
Papers to Note

[268] **Darren Millar:** This item on our agenda concerns the papers to note and we have the minutes of our meeting on 5 November 2013. I take it that those are noted. We will defer all the remaining items of business to future meetings, but, if you could stay around for a brief moment, I just want to touch on something before you all go. Thank you. The meeting is closed.

Daeth y cyfarfod i ben am 10:58.
The meeting ended at 10:58.