Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 3 Chwefror 2015
Tuesday, 3 February 2015

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Jocelyn Davies	Plaid Cymru The Party of Wales

William Graham	Ceidwadwyr Cymreig Welsh Conservatives
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

Steve Ashcroft	Swyddfa Archwilio Cymru Wales Audit Office
Lisa Dunsford	Dirprwy Gyfarwyddwr, Is-adran Integreiddio Polisi a Chyflawni, Llywodraeth Cymru Deputy Director, Integration Policy and Delivery Division, Welsh Government
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru a Phrif Weithredwr GIG Cymru Director General, Health and Social Services and Chief Executive of NHS Wales, Welsh Government
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio, Llywodraeth Cymru Director of Social Services and Integration, Welsh Government
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

Leanne Hatcher	Clerc Clerk
Tanwen Summers	Dirprwy Glerc Deputy Clerk
Joanest Varney-Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

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

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody. Welcome to today's meeting of the Public Accounts Committee. If I could just deliver the few housekeeping notices. If I could remind Members that the National Assembly for Wales is a bilingual institution and we

should all feel free to contribute to today's proceedings through either English or Welsh, as we see fit. In the event of a fire alarm, we should follow the instructions of the ushers, who will take us to a safe place. If we could all switch off our mobile phones to silent so that they don't interfere with the broadcasting equipment that would be much appreciated. There are no apologies for absence.

Papurau i'w Nodi
Papers to Note

[2] **Darren Millar:** So, straight into item 2 on our agenda, papers to note. We've got the minutes from our meeting on 27 January. I'll take it that those are noted.

09:01

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

[3] **Darren Millar:** Item 3 is a motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following items of business today: items 4, 6 and 7. I will move. Does any Member object?

Cynnig:	*Motion:*
bod y pwyllgor yn penderfynu gwahardd y cyhoedd o ran o'r cyfarfod yn unol â Rheol Sefydlog 17.42.	*that the committee resolves to exclude the public from part of the meeting in accordance with Standing Order 17.42.*

Cynigiwyd y cynnig.
Motion moved.

[4] Okay, we will go into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 09:01.
The public part of the meeting ended at 09:01.

Ailymgynullodd y pwyllgor yn gyhoeddus am 09:32.
The committee reconvened in public at 09:32.

Fframwaith Cenedlaethol ar gyfer Gofal Iechyd Parhaus y GIG: Sesiwn Dystiolaeth 1
National Framework for Continuing NHS Healthcare: Evidence Session 1

[5] **Darren Millar:** Welcome back to the Public Accounts Committee; we're back into public session on item 5 on our agenda—national framework for continuing NHS healthcare. We're taking evidence now from Dr Andrew Goodall, director general and chief executive of health and social care for the Welsh Government, Albert Heaney, director of social services and integration, Welsh Government, and Lisa Dunsford, deputy director, integration, policy and delivery division of Welsh Government. Is this your first appearance before the committee?

[6] **Ms Dunford:** It is, yes.

[7] **Darren Millar:** A very special welcome to you.

[8] Obviously, we're going to take a little bit of time this morning—I think you've been given a heads up—just to have a look at progress against the unscheduled care issues, as well, that the Auditor General for Wales reported on last year. So, we'll take about probably the last 20 minutes of our evidence session on that, and spend the first 40 minutes on the issues relating to continuing NHS healthcare.

[9] **Dr Goodall:** I wasn't aware of that, Chair, actually.

[10] **Darren Millar:** Okay. Well, it should've been relayed to you by the clerks. If you're not happy to do that, then—

[11] **Dr Goodall:** I'm happy to answer questions on it in general terms. I'm just saying that I'm not prepared for it, because I haven't been asked about it, but I can give my general reflections.

[12] **Darren Millar:** Okay, that's fine; that's fine. So, Mr Goodall, we've got, obviously, a copy of a report here, which is an update from the Wales Audit Office further to their work last year on continuing healthcare. The Public Accounts Committee also visited this last year, and made a series of recommendations. Frankly, I think we're a bit disappointed by the pace of progress. Whilst we can see clearly that some action has been taken to try and resolve the backlog of claims, it does appear that some are still taking a considerable amount of time. What action are you taking to get to grips with this problem?

[13] **Dr Goodall:** Well, I think our reflection on the auditor general's report from the Wales Audit Office is that it does reflect progress that we've had. My reflection on continuing healthcare is it remains a very complex and technical area. I was very involved with it as an LHB chief executive for 10 years or so—you get very involved in individual cases, as well as the general throughput of areas. I think we have been trying to ensure that we keep pace just with the level of growth in demand that's happened. One of my reflections, I think, that the service is still picking up at this stage is that we've grown from an area that requires both support and finance to be incurred that was, you know, around £50 million a year spend, going back 12 years or so ago, and has grown to something that is close to £300 million. And, clearly, what we need to ensure is that the infrastructure is able to keep pace with that.

[14] I think the other contrast that we're trying to deal with is a mechanism by which, at the same time we're able to deal with, you know, the retrospective claims process, which is a very visible issue, we can deal with our ongoing responsibility for people who are currently placed with continuing healthcare packages in a variety of different settings. At any one time, we have around 5,500 people placed in those types of beds and packages across Wales.

[15] I took the opportunity—also I'm required, I know—just to try and outline some of our own response to the WAO report. You can see that we've accepted many of those recommendations, but our general reflection as a team was that we did feel that we'd made some good progress, particularly over this most recent period of time, and had a lot of engagement, not just internally, but actually outwith the service and also with stakeholders. And I do think that the reframing of the framework that was issued, that has been available from 1 October last year and that involved around 100 stakeholders, means that there is a broader ownership, I think, than just what Welsh Government is overseeing.

[16] When you ask, 'Well, what are we doing about this to intervene?' we can deal with

that during the course of the questions, perhaps, but certainly I've made it very clear to health boards what my own expectations are. I've written out to the leads, who are now in place for all of the individual health boards, where there is a clear named person rather than just generally within the system at this stage. We have baselines for our performance monitoring that's in place, which allows us to have an understanding of how we're doing, and we've reflected recently on the balance between the local support infrastructure in place alongside what we want to facilitate on a national basis.

[17] We were pleased that the WAO has given credit for the way that the Powys project has been able to progress. Obviously, the backlog that was originally there of 2,500 claims has been worked through at this stage, and I think there's some success for us to build on there. But I'm mindful of trying not to answer potentially all of the questions that you want pose right at the outset, Chair. I'm happy to pick them up as we go along.

[18] **Darren Millar:** Well, let's come to Members' questions now and make some progress. I'm going to come to Jenny Rathbone first.

[19] **Jenny Rathbone:** Okay. Now that you've revised the tool, what do you think the potential is for people who were assessed under the previous tool to come back thinking that the new tool will give them a different answer?

[20] **Dr Goodall:** Well, we've done a number of consistency checks in terms of our experiences at this stage to make sure that there is consistency, but, Albert, I just wonder whether you want to just get stuck into that one.

[21] **Mr Heaney:** Happy to. Thank you very much, Dr Goodall. In terms of testing out the decision-support tool, we had a pilot in two of the local health boards. That pilot tested out in terms of the decision-support tool mechanism. Importantly, we also spoke in detail with colleagues in the Department of Health and with continuing healthcare leads in England to ensure that we had got the evidence base correct. During the piloting and a sample audit, what we found was that, for those citizens who have dementia, there was no marked difference. So, there was no issue arising for us in terms of concern. Of course, it's really important to keep sight of the fact that the decision-support tool is an enabler of a holistic approach, and therefore that adds greater value. So, for some of the concerns that were around when we met at the previous Public Accounts Committees, I feel that we have certainly progressed that to ratify and move forward successfully together.

[22] The one area where the evidence pointed to a potential difference related to people with a learning disability and, of course, as committee will be familiar with, people with learning disabilities can move in and out of continuing healthcare arrangements, and so the working arrangements with local authorities and health need to be very closely aligned in terms of partnership work. And in that area, what we have agreed to do through the local health boards is to review—there will be a review—of all of those cases that are jointly packaged between local authorities and health, to ensure that there are no discriminatory features. We're not anticipating any high numbers, but it's important that we undertake that review to ensure that we have the correct position in place.

[23] **Jenny Rathbone:** Okay, well, I'm sure colleagues will want come back on that one, but I'd just like to ask you about the peer review process of the annual audit samples and what that has done to enable you to try and get the poor performers moving up towards the better performers.

[24] **Ms Dunsford:** In terms of the sample audit, if I just add first of all that the sample audit also verified the findings of the pilot with the DST. So, again, there was no difference in outcomes for people with dementia, but there were in a few local health boards issues in

relation to learning disability. So, in relation to those cases, health boards will review those by the end of March and then will assess the situation then. More generally, I think, in relation to the sample audits, what we are finding across a range of areas is that there is variation between health boards. Now, some may be doing very well on training, some may have been struggling with retrospectives, but, in terms of the mechanisms that we are putting in place, we are gathering the information from the self-assessments, which were undertaken in February last year. The sample audits were undertaken in September and October and they were sample audits by a central team, rather than by peer review, but we would want to move to peer review in the future. We've also had the first quarterly baseline report as well. So, what we are doing is we have pulled that information all together in a draft report and Andrew Goodall has written out to the local health boards again, asking them to set out what action they are going to take where there is an issue with their performance. So, as I say, we completely accept that there is variation, but we do now have a lot more information from a range of sources that we've asked local health boards to respond on.

[25] **Jenny Rathbone:** Okay. So, Andrew Goodall, what is being done to actually raise the game of individual health boards that are simply not engaging with the process? There's nothing to review in most cases, in that in some cases—. I mean, Betsi Cadwaladr have had to pass all 317 claims, apart from a very minor number, over to the Powys project, and Cwm Taf only appointed somebody to review their CHC backlog back in the summer.

[26] **Dr Goodall:** I think we've done two recent issues in respect of that. One is that I've just written out to all of the leads, and I'll explain what my expectations are other than that, but, obviously, we are monitoring the progress that is being made. I had a discussion with the chief executives just earlier this month. Again, I think, building on the fact that Powys have clearly demonstrated their success in being able to get through volumes, as you highlight, there are a couple of health boards in particular that have, I think, struggled to get through their volume for respective issues on a local basis. Certainly, Betsi had indicated that they wished to confer some cases across to the central team within Powys. I sat down with the chief executives earlier this month and there was a discussion that was about using, actually, the expertise within the Powys project on an ongoing basis, and that we would look to deal with the phase 2 cases through that process. What that would allow is for the health boards to really focus on just getting their current capacity needs in place with the infrastructure, so that we break the cycle, which, I think, is necessary for us to work through at this stage, and would actually allow us to take full advantage of the experience and expertise that's within Powys going forward, over these next number of months in particular.

[27] What I'd say in defence of the service, however, in terms of the choice—. You may say, 'Well, why wasn't that just simply done in the first place?' I was a chief executive myself at the time when it was debated about going for the more federated model and making sure that we could have that hybrid, if you like, between using Powys's central skills and actually what we built up through the local health boards. My intention then, as a chief executive, was to say that, first of all, I took responsibility for it, so there was a need to make sure that we would make the necessary progress. The second issue was that I didn't simply want to distribute the expertise to a national programme, if I knew I was going to have some ongoing cases as well. I think the recent experience shows us that we can actually now fully rely on the Powys programme as a central project, but that we will at least make sure that the health boards can revert more to maintaining their local capacity at this stage.

[28] **Jenny Rathbone:** Okay. Well, that may be some comfort to people in Betsi Cadwaladr—

[29] **Darren Millar:** Sorry, I've got a number of Members who want to come in on just a few of these points. I'll come back to you, Jenny, in a second, but, first of all, Julie wanted to come in and then Jocelyn.

[30] **Julie Morgan:** Yes, I wanted to pick up the issue of people with a learning disability, because I do feel very concerned about this group of people, because they, perhaps, don't have a voice, or as much as many other groups do. I wondered if you could expand on the different approach that has been used throughout Wales. You've gone back to the local authorities to ask for more information on how they've been operating in relation to continuing healthcare. What sort of evidence has made you do that?

[31] **Dr Goodall:** I'll ask Albert to answer that.

[32] **Mr Heaney:** Thank you. I think the first thing was that the introduction of the new framework was a major step forward—it provides greater clarity. The decision support tool enables the holistic assessment to take place. But, of course, with individual citizens, their needs are very complex and, as we know from complex care, one has to do a detailed piece of work around each individual.

09:45

[33] With people with learning disabilities, sometimes their needs are predominantly social care needs, and on other occasions they are primary healthcare needs. The work that has taken place in the pilot, as I said earlier on, to test out the decision support tool, to make sure that there were no disadvantages to citizens, showed that there may be a small increase in terms of the number of people with learning disabilities. Now, that can be for a variety of reasons—people with learning disabilities requiring continuing healthcare. That can be for a variety of reasons. That can be because the eligibility threshold had been considered differently in different areas. The reason for having a decision support tool and the new framework is to achieve consistency, to ensure that those entitled will receive the services that they're entitled to receive. So, therefore, what we're doing is going back, really, to look at reviewing in detail with the local health board, with the social services department, to ensure therefore that some of those people who may have retrospectively been entitled to continuing healthcare; and if they had been disadvantaged, those will be picked up. We anticipate that that detailed work will take us a little bit of time, but the end date for completion of that review is the end of March 2015, this year. So—

[34] **Darren Millar:** Sorry; can you just explain? How many cases are you going back over to look at, then? That's what you're telling us you're going to do: you're going to look back at all the learning disability cases, effectively.

[35] **Mr Heaney:** Indeed.

[36] **Darren Millar:** Even the ones that have been closed.

[37] **Mr Heaney:** No, the ones that are currently—. What I mentioned earlier on, Chair—apologies for going back over, but I did reference that—it would be for those that are currently operating on dual packages, working across social care and health. So fundamentally, we're getting at those cases where it could be that they are currently receiving a service, but some of that service is funded by social care, and some of that service is funded by health, and they could have—if they do have a primary healthcare need—an entitlement to continuing healthcare. Therefore, it is that population that we will be going back and reviewing to ensure that there are no inherent disadvantages.

[38] **Julie Morgan:** Any idea of how many people we're talking about?

[39] **Ms Dunsford:** No, we haven't got the numbers, but there was one of the two local health boards in the testing stage that identified—so, you know, 50%. One local health board

did identify this issue, and in the sample audits that we undertook in September and October, which was then for all local health boards, there were two local health boards identified there. It doesn't mean to say there's only an issue in those two local health boards, because by the nature of the sample, we may have missed it in others. We haven't got the detail, but we could find the actual numbers for you. We've just asked the local health boards to review all the cases.

[40] **Julie Morgan:** I think it would be useful to have the details, just to know how many people we're actually talking about.

[41] **Darren Millar:** And just for the sake of clarity, on the comparison between decisions made under the old tool versus the new tool, you're basing your findings on just 10 cases, is that right?

[42] **Mr Heaney:** It's 20 cases: 10 cases in—

[43] **Darren Millar:** It says 10 in the report here.

[44] **Mr Heaney:** It's two local health boards and 10 cases in each local health board. It was anticipated that there would be a third local health board, but unfortunately they withdrew. It is upon that evidence and the sample audit, but also, Chair—to reassure you—we had detailed conversations with our counterparts in the Department of Health, and we also had detailed conversations with the continuing healthcare leads in England, as well. I'm certainly confident today in that the decision support tool that has been introduced certainly progresses us substantially forward. There are certain issues within; that eligibility has not changed. There is no alteration for where eligibility was in 2010 to where eligibility is today. The decision support tool enables the professionals to—

[45] **Darren Millar:** Okay. We're up against the clock this morning, Mr Heaney, so you need to be brief. So, 20 cases were looked at retrospectively to compare the scores that they achieved under the old decision support tool versus the new decision support tool. None of those changed. What proportion of those were learning disability? What proportion of those were cases where dementia was present?

[46] **Ms Dunsford:** With those 20 cases, they were looking explicitly, as I say, for differences in dementia—the 10 in each of the local health boards. As I say, one of the local health boards did identify a difference. Again, of the 10 in that local health board, I didn't ask how many had a different outcome, but, obviously, that information will be there, and, again, in the sample audit, there were two local health boards, but, again, we can provide the exact numbers for you.

[47] **Darren Millar:** The concerns that the committee had previously were that those people that might be particularly disadvantaged were those with dementia and those with learning disabilities. But you're not able to tell us what proportion of the 20, in just two of the health boards in Wales, were learning disability cases or dementia cases.

[48] **Ms Dunsford:** No, I apologise for—.

[49] **Darren Millar:** I mean we're talking about very, very small samples here, aren't we?

[50] **Ms Dunsford:** Yes, they are very small—.

[51] **Darren Millar:** How can you have absolute confidence that nobody is losing out or has lost out as a result of the previous decision support tool, because that's what we're looking for?

[52] **Ms Dunsford:** Yes, if I can just come in on that, I completely accept that they were small numbers for the testing stage. As I say, the sample audits were done. They will be repeated on an annual basis as well. So, all the evidence that we've had, albeit some of the numbers are very small, is suggesting that there isn't an issue in a difference in outcomes for people with dementia, but the evidence that we've gathered so far is suggesting that that is the case for learning disabilities, which is why we are reviewing all those extra cases, and we will know that outcome by the end of March.

[53] **Darren Millar:** So, can you drop us a note on how many of the 20 were cases where dementia was present or a learning disability was present, and, in terms of the two health boards that were assessed, which two were the ones that took part in this? Which two health boards was it that took part?

[54] **Ms Dunsford:** In terms of the audits, the issues that we found with the learning disabilities, it was Hywel—

[55] **Darren Millar:** I'm just asking which two health boards participated in those samples.

[56] **Ms Dunsford:** It was Hywel Dda that was involved in the first testing of the DSTs and it was Hywel Dda and Abertawe Bro Morgannwg University Local Health Board then that were picked up through the sample audit and identified the issue with learning disabilities. But we are asking all health boards to review their cases.

[57] **Dr Goodall:** Albert, do you want just to clarify on the 20 cases?

[58] **Mr Heaney:** Certainly, Chair, we will, of course, come back with information in the drop-down detail from the 20. I think what I would like to certainly reassure committee of today, very briefly, is that there was a sample audit done with two local health boards that did look at the dementia in all those cases, so the 20 looked at dementia. The issues around dementia were that there were no distinguishing features in terms of the overall decision support tool altering the final judgment. So, therefore, we have a confident—. Combine that together with the detailed—

[59] **Darren Millar:** You have confidence based on just 20 cases in just two health boards, and you can't even tell us what proportion of those had dementia present, can you?

[60] **Mr Heaney:** But, of course, Chair, we—

[61] **Darren Millar:** So, how can you have confidence if just two of those were dementia cases, for example?

[62] **Mr Heaney:** Well, they were all dementia cases, Chair.

[63] **Darren Millar:** They were all dementia cases.

[64] **Mr Heaney:** They were all dementia cases.

[65] **Darren Millar:** Oh, right, so they were all dementia cases.

[66] **Mr Heaney:** Yes.

[67] **Darren Millar:** All 20 of them.

[68] **Mr Heaney:** That was my briefing, Chair. All 20 cases were—

[69] **Darren Millar:** And some of those were learning disabilities and dementia.

[70] **Mr Heaney:** That's what I understand, Chair, and, with one board, it threw up that issue. And I think, importantly for the committee today, what we have said to committee, to reassure committee, is that we are reviewing all of those to make sure that there are no discriminatory features. So, I think, in terms of the right action that we're taking, there is an action that's coming out of this. From the learning from that, Chair, we will be pleased to come back and share that with committee to ensure that committee is fully sighted on all the learning that comes out of the review that takes place as well.

[71] **Dr Goodall:** In terms of the prospective issues, Chair, when I've written to the health boards, what I've asked them all to do is to look at the baseline for self-assessment tool and their own sample audits as well. So, part of the reporting environment that's now been created is to ensure that it's spread beyond just those original national pilots that we did at this stage, and that will be able to happen for each of the individual health boards. So, that will form part of the ongoing performance reporting mechanisms, which, again, is a change that we've introduced from 1 April.

[72] **Darren Millar:** Okay. So, if you can drop us a note, just to confirm that they were all dementia cases and that some of them were dementia with learning disabilities, I think we would appreciate that, just to establish the scale of the issue. Okay. I'm going to come to Jocelyn, who wanted to come in earlier.

[73] **Jocelyn Davies:** Yes, it was on something that was said earlier about the rate of dealing with the claims, because you said that you'd made it clear what your expectations are, you've met them, you've written to them. Can you tell us what the response is, because we've heard this from your predecessor as well? Actually, when I was on this committee, I remember that evidence session. And it's quite obvious that just setting out your expectations has not led to a step change in this. So, do local health boards not care what your expectations are?

[74] **Dr Goodall:** Well, I think the expectations that we've set are with a different set of environments. So, there is a different governance and accountability framework, there's a new performance reporting environment and, of course, we're using the refreshed guidance that was issued and has been in application from 1 October. From the Powys Project perspective, obviously, we did get through a period of time where we've managed to remove the 2,500 patients who were there, and that was to a successful outcome. What I'd reflect, perhaps, to answer the question, is that, if we could focus on the current rate as we see it, the run rate, for applications and what that would mean going forward, I think the WAO's report does actually deal with potentially how long that would take and whether that would be acceptable or not. What I would say, though, is that, because we looked at the run rate at this stage, that was one reason for driving the perspective of saying that we needed to now really properly centralise the Powys programme in order to allow us to both catch up and make sure that we could get through those in an appropriate timescale. But perhaps I could ask Lisa to give you the—

[75] **Jocelyn Davies:** So, their response to you when you met with them—

[76] **Dr Goodall:** The response rate was—

[77] **Jocelyn Davies:** —you know, with the LHBs—

[78] **Dr Goodall:** The LHBs understood, not least with the PAC having overseen the recommendations, with the particular reviews that have been done by the WAO, that,

although the intentions were there in respect of the federated model that had been established—and we should be fair and say that there are health boards that have made really good progress against those timescales as well, but for us to deliver that on a national basis required a different level of intervention, and that's why it was agreed that we would actually revert these cases to the Powys programme, and that they were being transferred over and that the infrastructure has been built up.

[79] The second thing that gives me confidence going forward is that the health boards have also committed as well the cost that it's going to take for us to process these between 2015 and 2017. So, rather than just leave it to local discretion, there was a collective business case that's been established, and that's going to require a £5 million investment to be going in over these two-and-a-half years or so to make sure that we can process those claims as well. So, again, that's a different system and a proper step up.

[80] **Jocelyn Davies:** So, the funding for the Powys project—.

[81] **Dr Goodall:** The funding for the Powys project is actually shared across the health boards themselves.

[82] **Jocelyn Davies:** Yes, so, they are now—

[83] **Dr Goodall:** They are actually contributing to that.

[84] **Jocelyn Davies:** And they are committing to that?

[85] **Dr Goodall:** Yes, and there's the disproportionate issue, where some areas have been slower in some of their uptake; there'll be a formula that actually allows that to be more fairly distributed across the health boards as well. So, that is a step change in terms of that response. What was really necessary, though, was, looking at the current run rates and the number of claims that were being processed, that we needed to be intervening now, and that was my intention by having the discussion with chief executives in January, and that was agreed.

[86] **Jocelyn Davies:** And you've got them all on board.

[87] **Dr Goodall:** They are all on board. They've all signed up to the business case. The Powys programme is now further recruiting to its own infrastructure to make sure that it can do that, and we can actually change the run rate of current claims to make sure that they will be cleared as originally intended. As you know, on the timescales that we're working to at this stage, we've tried to adapt those looking forward as well to make sure that they can actually be changed and pursued much quicker than previously. But there has been a change, I think, from the health boards to just recognise that.

[88] **Jocelyn Davies:** So, when there's a step change in their attitude, when will we see a step change in the processing?

[89] **Dr Goodall:** Lisa.

[90] **Ms Dunsford:** Yes, just to clarify, as I say, we were monitoring the responses by each of the local health boards to the retrospectives and, as I've said before, there was quite a big variability. Some local health boards wouldn't have been far off missing the numbers that they'd expected to deliver by December just gone, others were a long way off. I think someone referred to the issue with Betsi Cadwaladr, and they asked very early on for Powys to take on dealing with their retrospectives. But, as Andrew has said, when he met with the chief executives last month, there was agreement that all of the phase 2 retrospective claims would move over to Powys; as I say, some health boards are pretty near to completing theirs.

They did all agree to that. So, they are in the process now of being handed over. There was the business case, which has been signed off. What we need to go through in more detail is the contribution that each health board should make, because, again, I think, where some have put in capacity and have been delivering, their efforts should be recognised and those who probably haven't done what they should have done need to make sure that they provide that additional contribution. So, we were monitoring it. As I say, the progress was variable. You could arguably have left some of the health boards to carry on, because they have made pretty good progress, but the view was to hand them all over to phase 2, we've got confidence that Powys can deliver, and then the health boards will be dealing with their own claims, which we are looking at now on a monthly basis.

[91] **Dr Goodall:** As an example, Cardiff had led very well, for example. So, there are a number of health boards that had made very good progress, but we know that Cardiff had made some really good progress on the expected timescales and the volumes and the numbers as well.

[92] **Darren Millar:** So, you've signed the business case off—because it was just in draft form last week when you wrote to us.

[93] **Dr Goodall:** Yes.

[94] **Darren Millar:** That's now been signed off, but the cash isn't in place to support it as yet from the individual health boards.

10:00

[95] **Dr Goodall:** The health boards have committed that they are putting in that funding. It is obviously a prospective amount of funding, and it's spread over a two-and-a-half year period from 2015 to 2017. So, it will become part of the annual budgets that are allocated. But the authorisation had already been given to Powys to get on with their increased recruitment, because, although they've got their core establishments, obviously, now, they were taking on these additional cases. And the secondary issue is that there's still a need to draw in some of the local expertise within individual health boards, as well—they're still going to have to keep, I think, a very close liaison with the individual health boards. And the final bit, I would say, is that it does not take away any of the responsibility for the ongoing processing of continuing healthcare—not claims, but actually current patients who are being placed within packages of care.

[96] **Darren Millar:** Yeah. I'm going to come to Mike next, and then Sandy.

[97] **Mike Hedges:** The word 'business' has been mentioned very many times; well, if we're talking about a business, then health boards are wholly owned subsidiaries of the Welsh Government—in plain, classic business terms. It is an administrative function that is done by the health boards and it's all being moved to Powys. Why didn't you bring it in-house and take responsibility yourself? Instead of monitoring it, and looking at it, and doing checks on it, why didn't you actually bring it in-house and do it?

[98] **Dr Goodall:** Because health boards are individual organisations, so they have their own status to work this through. So, if there was a challenge against the individual health board, it will lie with them, rather than actually with Welsh Government. We have a system that requires us to process the patients in that way. I think also it's because we would have an expectation that health boards can, not just discharge it on a local basis, but actually have an opportunity to learn from and with each other, as they go forward at this stage. We clearly do have an oversight mechanism in place, and we do need to be monitoring the mechanisms, but Welsh Government is not established to process these claims directly themselves—they are

discharged actually through the individual health boards, based on their legal status.

[99] **Mike Hedges:** But the health boards' legal status can be changed by the Welsh Government at any time, they can be merged at any time, members of the health board can be removed at any time—and have been—all those things actually have happened in the last five years or so, haven't they? So, this idea—and you seem to be talking to us as if you're some sort of overviewing body, looking at these external things over which the Welsh Government has no control and could just give some advice on. And I think that, at some stage—. I mean, you're almost talking about this as if you are the health supervisory body for Wales, rather than, as I think it says here, the director general of health and social services and chief executive of the NHS in Wales. Now, if you're the chief executive, why aren't you chief executing these things?

[100] **Dr Goodall:** Because the responsibilities are split across the individual health boards. These are 5,500 patients who are placed every year. If you put it in the context of the beds that we have available in Wales, it's a very significant proportion of the overall beds. We have determined, from a Welsh Government perspective, to actually set in place these structures in Wales, which is that these are discharged through seven individual health boards and three trust organisations. I have an accountable officer status, and that accountable officer status is reverted downwards to the individual chief executives within the system. But the Welsh Government role is actually to provide the clarity of the policy and the guidance in the first place. I think we've discharged that by what was put in place from 1 October. We do have, of course, a monitoring role. We've enhanced, I think, the performance management expectations on this as well, and, even though we continue to oversee this, it's really important to make sure that we have the technical views involved from the stakeholders as well at this stage.

[101] **Mike Hedges:** Can I ask one final question? Do you think you've done a good job in looking after this?

[102] **Dr Goodall:** I think, as I said at the outset, the area of continuing healthcare is a really complex area—it's not just an administrative task, it's very professionally focused in terms of the individual skills and experience. I think that, certainly, as we look to place current patients in the system—. I know we're debating currently about the retrospective claims, and the need to actually work that through, in terms of the legal expectations placed on us, but we do place 5,500 patients every year. It's an area that's grown, as I've said, from a spend and individual patient size, from around £50 million a year 12 years ago to something that now takes up to £300 million-worth of funding on an annual basis at this stage. I think we have had to learn and expand. I think the criticism is whether we've expanded our infrastructure as quickly as possible to actually deal with the current pressures, as well as look backwards at this stage. I think we've tried to put that right in our responses over the WAO report and this recent period of time, and I do think that we're still learning and adapting. But I think that there is more that we can do, definitely, to improve it, and we accepted the WAO recommendations to get that next sense of improvement as well.

[103] **Mike Hedges:** I haven't got anything further.

[104] **Darren Millar:** Jenny, it's on this, is it?

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

[106] **Darren Millar:** If it is, very quickly—

[107] **Jenny Rathbone:** It's specifically on Cwm Taf, because they're the outlier now that Betsi Cadwaladr have handed over their—. You've got 67 claims that have been waiting over

four and a half years for Cwm Taf to process them, and the bar chart, on page 21, shows that, you know, there's something really odd and different to all the other health boards. What is being done to actually strengthen the health board so that they insist that the executive staff actually take action on this?

[108] **Dr Goodall:** Lisa, do you want to comment on the numbers, and I'll come back to the leadership within the individual organisations?

[109] **Ms Dunsford:** Yes. I know the report that you've got there was based on the November performance report. There is still, with the latest data, an issue in Cwm Taf where, again, they haven't been dealing with the retrospective claims. So, that is why, regardless of the variation in each of the health boards, all phase 2 are moving over to Powys. What we are continuing to do, though, is to try and, through the knowledge of the Powys team, share that amongst the health boards, so they need to ensure that they do develop their own capacity. So, again, we've been asking for information on the resource within each of the health boards to ensure that it's sufficient to deal with the claims. Also, we are going to be organising a learning event shortly as well, which will be an opportunity for the CHC leads to come together. So, Cwm Taf, on the latest figures that we've got, is still standing out as a problem, but Powys will be dealing with all the retrospectives for phase 2, but we will still be working with the health boards to ensure they do develop the capacity to deal with any new cases.

[110] **Dr Goodall:** There is a very clear executive lead now who oversees that mechanism. We've actually drawn in their nurse director as well, in respect of the support groups and some of the task and finish arrangements to make sure that Cwm Taf have clarity on there. Equally, because of the position that they've had, they will disproportionately have to pick up more of a contribution towards the Powys programme as well, so that others aren't disadvantaged by that. So, if you like, there is a disincentive in terms of getting it right.

[111] The final bit I would say is making sure that we really focus on their training needs for the future. We've got through very significant numbers for Wales, but we will be particularly targeting Cwm Taf on an ongoing basis for an improvement in their training levels of staff as well.

[112] **Darren Millar:** Sandy Mewies, and then I'm going to come to Aled.

[113] **Sandy Mewies:** Thank you. I'm afraid I've still got a number of questions for you. You said at the beginning of this process, when you began to speak, Dr Goodall, that this has been a very technical and complex process for you. It's been a very harrowing experience for those people who have lost loved ones, who are trying to get money back to which they are entitled, and some people who have seen relatives dying before any compensation could have been paid to them, because this has been going on for a number of years. What I'm not clear about is this: it's been a very inconsistent process over the time, it hasn't been evaluated and monitored regularly—I mean, that is quite obvious. We've got two health boards now, which are at the bottom of the pile—that's Cwm Taf and BCUHB—and now we've got your reassurance that everything's going to be well in the future. I'm not sure on what you're basing that.

[114] Some of the issues that are clear to me are: BCUHB, for example—I'm not sure what the figure was you said would be put in by health boards over the next two years. How much was it?

[115] **Dr Goodall:** It is £5.6 million, currently.

[116] **Sandy Mewies:** Right. Now, we already know that health boards are facing financial difficulties; we also know—I know, specifically—as you do, BCUHB is facing financial

difficulties. Are you sure that all these people, all these health boards, are going to find the money to put in, because, if they don't, you're heading for another failure and you're heading for a failure where many of the people now will either give up or, I'm afraid, they will have passed away, which is what's happened in the past? That's the human face of what you're talking about here.

[117] We also note things are going back to Powys. There was a national task and finish group there, and we're told in the report that some people didn't bother attending meetings. It's gone back to Powys now; I don't know if it's the same group who are going to be doing it, but, if it is, how are you going to guarantee that they don't say, 'It's lack of video-conferencing. We can't get there; leaves on the rails'? I don't know—all those reasons. What sanctions will be available to see that this process that you're talking about will work properly?

[118] I think the other thing—well, there are two more points I want to make, and one is publicity. The publicity was extremely poor over the last few years. Information leaflets in doctors' surgeries—if you picked up a leaflet, great. I can tell you from personal experience that people in the situation of having a relative going through a battle for continuing healthcare—in my case, one I didn't continue with, and I was fortunate that I was able to do that from a financial perspective; some aren't. How are you going to publicise this properly? And I don't mean by information leaflets left here and there and I don't mean on the web; I mean, actually, by getting across this message to people that this has changed—'You may be able to enter this process'. So, how will that be done?

[119] **Darren Millar:** Shall we let the witnesses answer those questions first, then I'll come back to you?

[120] **Sandy Mewies:** I've only got one more.

[121] **Darren Millar:** Okay, very briefly.

[122] **Sandy Mewies:** I'm always forgetting what it is now, because I'm exhausted by this process, never mind any other. [*Laughter*.] But, you see, for me, it's been a shambles, really, and I don't say that lightly. It's been a shambles, the way it's been handled. How can you be so confident? You talk about diagnostic—these tools that you use. There were tools before. They didn't work. So, how can you be sure that, this time round, they are going to work and give people a fair result?

[123] **Dr Goodall:** Okay, there are about six different issues there. First of all, my introductory comments were just to try to convey some of the complexity around it. They were not at all to detract from the individual impact that that has for people being processed.

[124] **Sandy Mewies:** But we can't forget that, can we?

[125] **Dr Goodall:** No, absolutely, and I would absolutely agree with you on that. I think, irrespective of the fact that people have legal rights to have this process at this time, it is to be done in a sensitive manner. It's to recognise their particular circumstances as well and it's to try to deal with it as professionally as possible. I wouldn't want people to feel that it is technical in that sense. I appreciate that every one of these cases has very much an individual and family impact as well.

[126] In terms of the commitment by LHBs at this time, you are right that there are financial pressures that LHBs, of course, need to discharge, but this is also about discharging their legal function, which is core business for them within their organisations. I've got no hesitation that, with the agreement for covering that cost and the way that we facilitated it,

that will be part of the annual budgets. Irrespective of other pressures that people will have to handle, this will not be at risk in terms of that going forward, which is why we're already progressing with the expansion of the recruitment that is necessary, both on a local and on a national mechanism through the Powys programme at this stage. I think that you'll just have to leave that one with myself, but I'm very clear that that's been signed up to by individual organisations as part of the core budgets.

[127] **Sandy Mewies:** And it will be monitored?

[128] **Dr Goodall:** Absolutely. We'd make sure that that happened. In terms of the publicity arrangements, if you could pick that up, perhaps, Lisa, you could just comment generally on that about what our intentions are for the future and how we'll tighten it up with the individual health boards.

[129] **Ms Dunsford:** Yes, in relation to the publicity, I am sure committee is familiar with what was done last time. You know, I accept that there is always a criticism that you can do more. But, from our perspective, as I say, we did the press notices, we contacted local health boards, local authorities, other stakeholder groups, including Age Cymru and others, asking them to make the information available and signposting to the helpline and the information leaflets on the website. We did actually take out some adverts as well in 12 newspapers at the end of June. What we have recognised is that there was variation in the distribution of that information, so the intention now would be—we've re-run extra copies of the leaflets. We will be more prescriptive in terms of where they should be distributed. I know in the audit report they were saying that they should be available in care homes. We are looking at the posters as well, because they are things that people will be able to see. So, it won't just be people in the system. They will be there for people who haven't yet come into the system and, through the new governance arrangements, we have established a sort of stakeholder group as well, which met last week. Again, we will be seeking views. So, I accept there's always more that you can do, but we'd felt that we had done—

[130] **Sandy Mewies:** But, specifically on that, when somebody actually enters the system, at the very beginning when they enter the system, will you be telling them then, giving them then the information, so that they can self-monitor themselves to see if they, or the person they care for, is being dealt with properly, because, you know, it can go on for years, as you are aware? I mean, are you considering doing it upfront as well as retrospectively?

[131] **Darren Millar:** Albert.

[132] **Mr Heaney:** The answer to that is 'yes'. I mean, it's very important that the whole system ensures that people have the right information at the right time. That is the commitment that we have given. The number of the questions that you have referenced—what is the difference between the day that we currently set out to and where we were a few years ago? Is it that the framework makes it mandatory? So, for the tool, there is an absolute requirement that professionals must use that material in a holistic way. So, in terms of some of the anxieties that have been around things that have gone wrong, or haven't gone in the pathway that we wanted in terms of both process and timeliness, the actions taken by Welsh Government have been to set the standards in place that can be adhered to.

10:15

[133] The way that we must work together is through the leadership. The director-general has asked me to jointly chair with the lead chief executive from a local health board the national complex care board, and that board will look at the performance; it will look at these issues in substantial detail, so that we will drive together to make sure that the avoidance of dealing with good performance or bad performance won't be—. We will look at both good

performance, share the learning, but also look at where poor performance is and use that to enhance and develop and really move the timeliness. Because what we're trying to do is break the cycle here, and there has been a cycle of retrospective delays. And I think that the process that we've tried to put in place and the timelines we've tried to put in place are about shifting that, because, as you say, it's the person at the centre of this and the family members at the centre of this, and that's why it has to be done and delivered in a wholly different way in the future.

[134] And my last comment, Chair, was just to say we have got the complex care information and support website up and running as well, and I got on to that this weekend and had a look at it, and it is a much greater development in terms of being user-friendly for both those citizens and professionals to have information available to them.

[135] **Darren Millar:** Sorry, just for the sake of clarity: the board is replacing the functions of the task and finish group; that's been disbanded, has it?

[136] **Ms Dunsford:** It hasn't yet, but arrangements will take place from April. As I say, there are two areas, the national board that Albert will co-chair with the chief executive. That first meeting is planned for April, and we've also then got the complex care steering board which Albert chairs, and that was the one that met last week. So, that's the position that we are at at this point in time.

[137] **Darren Millar:** So, there's a complex care steering board and a task and finish group, both running in parallel, both looking at the same issue.

[138] **Ms Dunsford:** Sorry, it was a stakeholder reference group—apologies—that sits underneath.

[139] **Mr Heaney:** One will be the board, Chair, and the other is a stakeholder reference group with key stakeholders able to challenge and scrutinise the process but also the performance information, and we had a very helpful discussion last week that really started that—

[140] **Darren Millar:** And just to answer Sandy Mewies' point directly, she did ask: is the information about the ability to challenge a community health council decision being made available to people at the time they receive a decision on either their care or their loved ones' care?

[141] **Dr Goodall:** That's our expectation and our intention. Obviously, as we go through the training aspects and we continue to work through those modules, it makes it more ingrained, more visible to the professional staff who are involved in this. But, our expectation is that it starts to be dealt with upfront in the pathway and experience, and not just at the end point.

[142] **Darren Millar:** Yeah, okay. Happy with that, Sandy?

[143] **Sandy Mewies:** Yes, thank you.

[144] **Darren Millar:** Aled Roberts.

[145] **Aled Roberts:** Rwy'n symud at y trosolwg cenedlaethol yma. Wrth gofio pa mor sâl oedd presenoldeb ar y grŵp gorchwyl a gorffen, a fydd cofnodion y grwpiau rydych chi wedi cyfeirio atyn nhw funud yn ôl yn

Aled Roberts: I want to move over to this national overview. Given how poor the attendance was in terms of the task and finish group, will the minutes of the groups that you referred to a moment ago be public ones so

rhai cyhoeddus er mwyn i ni weld a oes yna fyrddau iechyd sydd ddim yn danfon cynrychiolwyr, fel ein bod ni fel cynrychiolwyr lleol yn gallu gweld pwy sydd ddim yn derbyn cyfrifoldeb?

that we can see whether there are health boards who are not sending representatives, so that we as local representatives can we see who's not taking responsibility?

[146] **Dr Goodall:** Certainly, in asking on that and how we handle it, first of all, I would say that yes, we can make sure that people are aware where there's been a problem about local attendance and those issues as necessary. But, I would also suggest that we can act differently in terms of the way in which I would be looking to intervene along with the team anyway, and it would not to be tolerating the fact that people would not attend in the first place. I've already intervened differently just over these recent weeks or so to make clear expectations. And I know that there has to be some trust about why would that be different at all, but we are expecting to use these frameworks in a very different manner from before. So, yes, we could make it very visible about where there's been a problem with local attendance, but my expectation would be there shouldn't be a problem for the future anyway.

[147] **Aled Roberts:** Ocê. Rwy'n synnu eich bod chi wedi dweud yn gynharach bod yna un bwrdd iechyd wedi tynnu allan o'r adolygiad. Sut mae yna wasanaeth cenedlaethol sydd, fel roedd Mike Hedges yn gyfeirio ato, yn rhan o wasanaeth cenedlaethol sy'n cael ei weithredu gan Lywodraeth Cymru? Sut mae un bwrdd iechyd yn gallu tynnu allan o adolygiad, a phwy oedd y bwrdd iechyd yna?

Aled Roberts: Okay. I'm surprised that you said earlier that one health board has withdrawn from the review. How is there a national service, as Mike Hedges referred to, a part of a national service that's being operated by the Welsh Government? How can one health board withdraw from the review, and which health board was that?

[148] **Ms Dunsford:** Okay, there were three health boards going to be involved in the testing of the DST. One of them did withdraw from that. I'm not sure of the reason why.

[149] **Aled Roberts:** Who?

[150] **Ms Dunsford:** I don't know that one; I'll have to get back to you—apologies, Chair—on which one it was. But, what we have got is that all of the health boards have had to undertake the self-assessment. All of the health boards have been involved in the sample audits as well. All of them do need to provide quarterly reporting. So, there was only an issue with one health board—

[151] **Aled Roberts:** Ond sut mae gwasanaeth iechyd cenedlaethol—gwasanaeth iechyd cenedlaethol sydd i fod yn dangos trosolwg ar gyfer Cymru—. Pe buaswn i'n brif weithredwr bwrdd iechyd sy'n perfformio'n wael, y cwbl y byddai'n rhaid imi ei wneud yw danfon llythyr i Gaerdydd yn dweud nad oeddwn yn fodlon cymryd rhan yn yr adolygiad.

Aled Roberts: But how can the national health service—a national health service which is supposed to show an overview of Wales—. If I was a chief executive of a health board that was performing poorly, all I would need to do is send a letter to Cardiff to say that I wasn't willing to take part in the review.

[152] **Ms Dunsford:** Chair, if I can just confirm, it was a voluntary basis, where health boards had agreed that they would test out the decision support tool. So, as I say, there were three that did volunteer—we did only end up in two. I accept what you're saying—we wouldn't want someone to withdraw from something that is a mandatory process, but that was done more on a volunteer basis. We did ensure that everyone, as I say, was involved in the sample audits, and they do have to provide performance information, and everything else.

[153] **Dr Goodall:** I think, for clarity, they're not withdrawing from the whole process, because, of course, they've got to discharge that as a legal duty. What they were originally able to decide was whether they wished to use the Powys programme or whether they wanted to maintain that as local infrastructure at this stage. But, certainly, now, everybody has signed up, as I said earlier, to the fact that every health board will be part of the Powys programme at this stage.

[154] **Aled Roberts:** Ond os ydw i'n ddinesydd sydd yn byw ym mwrdd iechyd Betsi Cadwaladr, neu yng Nghwm Taf, rhaid imi ddisgwyl gwasanaeth llawer iawn salach na'r rhan fwyaf o fyrddau iechyd. A ydy hynny'n dderbyniol o fewn gwasanaeth iechyd cenedlaethol yng Nghymru? Beth ydych chi wedi'i wneud ynglŷn â ffigur 10, ar dudalen 42 o'r adroddiad gan yr archwilydd cyffredinol? Mae Cwm Taf yn dweud eu bod nhw'n dal i ddisgwyl y bydd yn cymryd 30 mis iddynt ddelio â chais, a Betsi Cadwaladr 28 mis. Roeddwn i'n meddwl bod Llywodraeth Cymru wedi derbyn argymhelliad y pwyllgor yma mai dim ond dwy flynedd ddylai unrhyw un aros.

Aled Roberts: But if I'm a citizen who lives in the Betsi Cadwaladr health board area, or in Cwm Taf, I have to expect a much poorer level of service than the majority of health boards. Is that acceptable within a national health service in Wales? What have you done about figure 10, on page 42 of the report by the auditor general? Cwm Taf says that they still expect that it will take 30 months for them to deal with a case, and Betsi Cadwaladr 28 months. I thought that the Welsh Government had accepted the recommendation of this committee that no-one should have to wait for more than two years.

[155] Felly, rydych chi wedi dweud wrthym eich bod chi'n monitro, rydych chi'n derbyn ystadegau—yn fisol, rwy'n cymryd—beth ydych chi wedi'i wneud ynglŷn â'r byrddau iechyd yma sydd ddim yn perfformio, ac sydd ddim wedi perfformio ers blynyddoedd? Ac a gaf fi ofyn i Mr Goodall: roeddech chi'n dweud bod yna resymau lleol dros y ffaith bod bwrdd iechyd Betsi Cadwaladr ddim wedi perfformio'n dda iawn. Beth ydy'r rhesymau lleol yna?

So, you've told us that you're monitoring, that you receive statistics—monthly, I presume—but what are you doing about those health boards that are not performing, and haven't performed for years? And could I ask Mr Goodall: you say that there are local reasons for the fact that Betsi Cadwaladr health board hasn't performed very well. What are those local reasons?

[156] **Dr Goodall:** I think, in respect of the current progress being made with the numbers of cases, and referring to the graphs that the WAO set out, that partly drove, actually, the reason for intervention, and having the discussion amongst the chief executives in a different way, that said, actually, rather than wait until the end and acknowledge that there was a problem looking backwards, it's actually to say that, if we don't intervene differently, there will be a problem in actually keeping up with these numbers of cases going forward. Hence, the decision to actually move the phase 2 cohort to the Powys programme: it's to allow us, actually, to ensure that we will go through the appropriate numbers per month, in order to meet the requisite timescales at this stage.

[157] For Betsi Cadwaladr, there were some very specific issues. I mean, certainly, despite the volume and numbers of cases that they had, there was a need—and they did declare earlier on their wish—to transfer cases over to the Powys programme. They had had difficulties, I think, recruiting to the professional roles that they had in place for these, and actually dealing with some of their backlog at this stage. Having said that, the Powys programme will also ensure that, disproportionately, they will catch up more with Cwm Taf, and Betsi Cadwaladr as well, because a higher number of cases will actually be going through at volume, because they just have a higher backlog at this stage. They will still be worked through in

chronological order, of course, which is the underlying principle as well.

[158] **Aled Roberts:** Did you test those recruitment issues, as far as Betsi Cadwaladr is concerned, because it is quite a common explanation for all the difficulties they have?

[159] **Ms Dunsford:** No. As I say, we didn't sort of test the recruitment issues. I think, you know, there was—

[160] **Aled Roberts:** So you can't tell us whether or not they actually sought to recruit, or how long it took them after—. There are instances in Betsi Cadwaladr, where, if somebody retires, for example, it can take them 10 or 12 months to decide to recruit someone. Did you check out their failings in this particular area at all?

[161] **Dr Goodall:** We'd have to check on the specific aspects. I can't reply to that particular issue at this stage. What I do know, however, is that, rather than waiting until our discussion this month, Betsi Cadwaladr actually ended up brokering the fact that they wanted to transfer the cases, so they knew they had a local infrastructure issue with capacity. Of course, on the two health boards that had had the highest volume of cases at this stage—and I don't know some of the issues there—certainly, Aneurin Bevan and Betsi were the two that were of a higher level. I think that was just early recognition that they couldn't deal with it with the pairs of hands they had locally. Certainly, going forward, my expectation is that we do need a confident statement about their ability to keep up with the current pressures and demands placed upon them for continuing healthcare, but, Chair, I'd have to respond to the particular issues there; all I know is we acknowledged their request to transfer to the Powys programme.

[162] **Aled Roberts:** Perhaps you can confirm, if you're providing us with a note, whether they're not now at full strength, so that we don't receive the same explanation in two years.

[163] **Dr Goodall:** Okay.

[164] **Jocelyn Davies:** Can I just ask, do you need a lawyer to do this work? I mean, I know that they've had problems recruiting consultant surgeons, and so on, there. I mean, is everybody working in north Wales saying that they don't want to do this sort of work? Is this administrative?

[165] **Dr Goodall:** There's a balance of the different expectations. There is an administrative element overall, but there's also a high professional aspect, so you tend to get highly experienced senior nurses with a complex care background who are able to discharge and process this. So, although, I think, we can still continue to mitigate going forward and train, and you can actually allow for some of the administrative tasks to be done in a different manner, a lot of it is really based on these professional judgments that are being made on the individual criteria.

[166] **Jocelyn Davies:** So, you would need somebody who is a specialist. This isn't just an admin job. You'd need somebody—

[167] **Dr Goodall:** No, no. You do need specialist complex care experience. As I said earlier, if you take an infrastructure that's grown from this sort of £50 million a year spend up to £300 million, that growth of expertise has had to happen over the years, but it's to keep pace with the current pressures and demands on the service as well as the retrospective claims. We're obviously trying to discharge both at the same time.

[168] **Ms Dunsford:** What has happened is, I think, that, again, some health boards—whilst there are areas that do need to be looked at by a professional—were potentially using those

for jobs that could be done by an administrative person. So, again, I think that's been picked up and shared. So, in terms of pulling together the information for the chronology, again, that is a job that can be done by an admin person, so that advice has been given out to the health boards, as well.

[169] **Darren Millar:** Thank you. William Graham.

[170] **William Graham:** Thank you, Chair. In the WAO survey, three of the health boards expressed advocacy services as a concern. What value do you place on advocacy services?

[171] **Dr Goodall:** Albert, would you like to reply?

[172] **Mr Heaney:** Thank you for the question. We place a high value on advocacy services. For those who are entitled to statutory advocacy, for example through the independent Mental Capacity Act 2005, then they will receive a service. For those who do not receive an advocacy service through that statutory route, we have worked with the Wales Council for Voluntary Action and have hosted an actual annual national event for advocates to meet together about the service provision across Wales. We have attended, as well, to talk to the advocates through their own arenas, through the national advocates and advocacy regional events, and also we are looking actively in terms of what this framework now says is a duty to offer advocacy, rather than base it upon a need. So, again, in terms of our steps forward, they're significant steps from where we previously were placed.

[173] **William Graham:** In terms of the patients and their families, in terms of the advocates themselves and the consistency of their qualification and experience, how do you get over that in making sure they have an equitable settlement?

[174] **Mr Heaney:** In terms of the advocacy, for those who have an advocate, obviously those advocacy services will be trained and will have the advice given to them. In terms of those who select a family member, then support arrangements can be in place, but it's important to distinguish the difference. If a family member is chosen by a citizen, by an individual, by a person to advocate for them, they have chosen them as the best person to represent them. It's important that they represent their views, and not, in a sense, that they've become an expert in what is a very complex arena.

[175] **William Graham:** Indeed. So, you were saying you place a value on this service, though do you think it will actually help to settle some of the claims in a reasonable manner?

[176] **Mr Heaney:** We would certainly believe, and we would advocate, that advocacy is an important part of assisting people through the process, and ensuring that it's dealt with in a timely fashion. All of this is about ensuring that the whole process is improved, and advocacy is an important aspect of delivering upon that.

[177] **William Graham:** How will it now be improved?

[178] **Mr Heaney:** In terms of advocacy provision, in terms of the offer, it's an active offer rather than being based upon a perceived need. The work that we're doing with the Wales Council for Voluntary Action is ensuring that that is across the Welsh nation.

[179] **William Graham:** Okay.

[180] **Darren Millar:** So, who's providing this advocacy at the moment?

[181] **Mr Heaney:** There is a range of advocacy providers, and that's where the Wales Council for Voluntary Action is assisting us, as a Welsh Government, in working with those

providers. As I mentioned, Chair, there are national arenas for the advocates who provide advocacy to come together in terms of support. We indeed have held, sponsored and facilitated an all-Wales event in terms of national advocacy, in relation to delivering advocacy for those in receipt of complex care.

[182] **Darren Millar:** In terms of monitoring access to advocacy and quality of advocacy, I mean, how do you do that, as a Welsh Government?

[183] **Ms Dunsford:** We are going to be introducing, as part of the monitoring arrangements, a customer feedback mechanism, as well. We are expecting that to be up and running from April. So, again, that will provide us with an opportunity to gather views from people as to whether they got the care and support they needed, if it was in a timely manner. So, the introduction of a customer feedback mechanism into performance management would be the best way to pick that up.

10:30

[184] **Darren Millar:** And you're going to measure whether advocacy was offered and how easy that was to access, are you? How are you going to pick up on the quality, though? It's going to be difficult, isn't it? This is a once-in-a-lifetime experience for most people, isn't it, having to do battle with a health board over continuing healthcare? So, how on earth is the patient or their loved one going to be able to determine whether they are getting a fair hearing or not, unless there's someone like an advocate who experiences this stuff on a daily basis and builds up a pattern of casework where they are able to challenge more easily?

[185] **Ms Dunsford:** I think, as I say, there are different levels and arrangements for advocacy. I think the customer feedback will be an opportunity. We'll be asking general questions, but equally, if we identify there are specific issues, we can look at those in more detail.

[186] **Darren Millar:** How on earth is customer feedback going to be able to determine whether the advocacy is good or not, and the quality of that advocacy and the knowledge of the advocate?

[187] **Ms Dunsford:** It's going to be looked at as part of a rounded sort of system—

[188] **Darren Millar:** So, what else are you doing in addition to the customer feedback, on advocacy?

[189] **Ms Dunsford:** It's mainly, I think, in relation to the working with WCVA to make sure that advocacy is available to meet the needs of people who do require formal advocacy support, rather than using a family member. So, we are doing that. I accept what you're saying about customer feedback, that it may not cover it all, but that is an area that we are looking at and developing. We can raise it again with our stakeholder group as well, to gather more views on that—[*Interruption*.] Apologies.

[190] **Darren Millar:** I'll bring you in in a second Mr Heaney. I just want to bring Aled in, and then I'll bring you back in.

[191] **Aled Roberts:** Mae'r fframwaith yn dweud y dylai pob bwrdd iechyd ystyried pa mor ddigonol yw gwasanaethau eirioli. Felly, a yw'r byrddau iechyd wedi? A ydych chi wedi derbyn adroddiad gan bob bwrdd iechyd yn dweud beth yw eu barn ar a yw'r

Aled Roberts: The framework says that every health board should consider how adequate their advocacy services are. So, have the health boards? Have you received a report from every health board saying what their views are on whether the service is

gwasanaeth yn ddigonol? A yw'n bosib hefyd ichi roi nodyn inni ynglŷn â maint y tendr gan bob bwrdd iechyd ynglŷn â gwasanaethau eirioli ynglŷn â gofal iechyd parhaol?

adequate? Is it possible also for you to provide us with a note about the size of the tender from each health board relating to advocacy services for continuing healthcare?

[192] **Mr Heaney:** Thank you for your question. Certainly, we will be happy to provide a note in terms of detail, post this committee hearing today. In terms of advocacy, we see the process working, but the responsibility lies with local health boards, and therefore monitoring arrangements through the performance management needs to be in place. We also see it being an important dialogue with the advocacy providers themselves, through the Wales Council for Voluntary Action. So, in terms of feedback, I think it's feedback from customers, but adding to what was being described by Lisa this morning. We see feedback coming from the advocacy services themselves, so we can get a real rich picture.

[193] Importantly, advocacy is one element of the framework's engagement with citizens, but actually the care co-ordinator is also an important role. The training and workforce development for those interested individuals is about moving the system away from what can be an adversarial system into a customer-focused system. So, we would hope that, by the communication through care co-ordinators, they would ensure—and that it is part of the training and workforce development—that the information that individuals need to make informed choices and be part of the system is proactive. So, again, it's not just looking at it from one angle. This is multilayered in terms of citizen engagement, Chair.

[194] **Dr Goodall:** Chair, as we fill in the detail of the quarterly reports—obviously, we are now in a different cycle—in April, we'll have the first chance to look at that as a proper report, which takes us through January to March. We'll just reassure ourselves in that as to whether that particular component that's been highlighted by the committee today is sufficiently dealt with within that. Because there'll be a lot of numbers, a lot of different perspectives clarified, and we'll use that first report just to test that.

[195] **Darren Millar:** Sorry, Aled, you wanted to come back in.

[196] **Aled Roberts:** Roeddwn i jest yn meddwl, rydym ni eisiau mwy na gobaith. Rydym ni eisiau sicrwydd. Rwyf jest yn gofyn ichi a ydy'r byrddau iechyd wedi cynnal asesiad ynghylch gwasanaethau eirioli? Beth yw'r gwerth ichi drafod gyda'r WCVA os oes gyda chi ddim barn gan y byrddau iechyd eu hunain ynglŷn â pha mor ddigonol yw'r gwasanaethau eirioli ar hyn o bryd? A ydych chi wedi derbyn asesiadau gan y byrddau iechyd?

Aled Roberts: I was just thinking that we need more than hope. What we want is certainty. I am just asking you whether the health boards have undertaken any assessment relating to advocacy services? What is the value of your discussing with the WCVA if you don't have the opinion of the health boards themselves about the adequacy of advocacy services at the moment? Have you received any assessments from health boards?

[197] **Mr Heaney:** No, we haven't at this stage received assessments from the health boards directly, although there have been conversations with each and every local health board, and that is something we will take forward post this meeting today.

[198] **Darren Millar:** Can I just ask, on advocacy, before I raise one other issue with you, is there a role for community health councils in providing advocacy to people who want to challenge a CHC decision?

[199] **Dr Goodall:** I'm not aware that we draw that in. You're right to refer to the fact that there's a general complaints advocacy role that is actually hosted and accommodated by the

CHCs across Wales. So, one would expect that, perhaps, as part of a complaints mechanism, if somebody had a real issue, you shouldn't be precluded from going through that kind of mechanism. I don't think we've really thought it through in that mechanism, mainly because we've tried to make sure that there's a very direct and relevant set of advocacy that's available. I can certainly look to clarify that to make sure that at least the system is clear to anybody and the complaints process itself wouldn't preclude them from at least raising it with the CHC in the first place.

[200] **Darren Millar:** Yeah, and I suppose it's one way to establish a bit more consistency. Jocelyn.

[201] **Jocelyn Davies:** So, with the quarterly reporting, would you know who the advocates are? Are you collecting those data? You said that this is the first; so, would you know if people were using lawyers or community health councils? Would you know?

[202] **Dr Goodall:** We've not done that, yet, because obviously we've set up a new performance reporting mechanism. Although we've set the baseline with some of our early figures, it's going to be our look back on January to March as the first period. I think that will be both a narrative and a set of numbers and the processes at this stage, and that's what we just need to test and work through in terms of first receipts.

[203] **Jocelyn Davies:** Right, so when you get that after your first quarter, will it tell you—. Will the information be there so that you'll be able to say, 'Well, hardly anybody's using a lawyer; nobody's using a community health council; everybody's doing this themselves or asking their next-door neighbour'. Will you have that information after the first quarter?

[204] **Dr Goodall:** Well, we'll be able to see if it's there, or not. If it's not there, we can clarify it and, obviously, on the back of today's discussion, I can see that it's a very specific issue for the committee and we'll make sure that we don't just leave it until the end of March. We'll make sure that that's—

[205] **Jocelyn Davies:** I see, so it's something you can add in.

[206] **Dr Goodall:** If we don't feel it's appropriately covered at this stage.

[207] **Jocelyn Davies:** Right, okay.

[208] **Darren Millar:** Just two very brief questions to conclude this session, and we won't move on to the unscheduled care issue, given that you weren't prepared.

[209] **Dr Goodall:** I will try to find out—

[210] **Darren Millar:** It's quite okay, and it's given us an opportunity to explore this in more depth, in any case. Paragraph 2.37 of the auditor general's report refers to a discussion that is taking place, a live discussion, in the task and finish group regarding a possible extension of the two-year deadline so that it becomes three years to review a case once a challenge has been lodged, effectively. Where does the Welsh Government fit in in making those decisions? Why is the task and finish group able to determine that? Given that this committee made a clear recommendation that there should be resolutions within two years—not just reviews, but resolutions within two years—I suspect that Members won't be very comfortable with what appears to be something that alludes to the possibility of significant extension to that.

[211] **Dr Goodall:** Chair, I'll comment generally and then I'll ask Lisa to pick up the detail. My general approach on this is that we have tried to make sure that we don't just make the

decisions in isolation, but that our processes still make sure that we take advantage of the wealth of experience that is out there and the range of stakeholders. I think that a strength, actually, of setting up the framework in the first place and having it in place from October is that it comes with a lot of support from the various stakeholders that have been involved in the mechanism, and we wouldn't want to take that away. We do need to continue to make sure that we learn going forward, but you're right, there's a moment for actually calling, what is the advice and what are the areas. I hope I've indicated today that we are already intervening differently in some perspectives on the back of the recommendations. If you want to deal with the specifics—

[212] **Ms Dunsford:** Yes, just to pick that up in more detail, that would have been looked at in terms of the current timescales for dealing with cases by each of the health boards. As I said, it's not formally come to Welsh Government to ask us to extend the timescale. As I said, we've been very clear that it should be within two years and, actually, the revised framework looks to reduce the timescales for completion, going forward. So, as part of the business case, we were asking for them to calculate what resources would be required to stay within that two-year deadline, but we will be making sure and monitoring that that is the case. We wouldn't want it to be moving or to extend it even more.

[213] **Darren Millar:** Just to be clear, in terms of your position, you don't want to see that two-year goalpost move to a three-year goalpost.

[214] **Dr Goodall:** No.

[215] **Darren Millar:** And what about tightening the goalposts? You've indicated already, Lisa, that that's something that you're hoping to do in the future, but what about tightening the goalposts so that there's a clear resolution within the two-year period, as recommended by the Public Accounts Committee in our previous report—a recommendation that you accepted, by the way, but seem to interpret differently.

[216] **Ms Dunsford:** Yes, what we've done, just to clarify, is that the revised framework does change the timescales from two years to one year to six months. In terms of what we said, we weren't trying to change the goalposts; our deadline was always that the cases would be reviewed and that was delivered by Powys. We do accept the point that has been made by WAO that, actually, that could mean that some cases drag on longer before they are fully completed, resolved and reimbursement is made. So, we are looking, again, in line with the recommendation, to provide additional guidance, which again will tighten up on the timescales for writing out for proof of payment, for calculating the reimbursement. We did used to collect the average time for resolving cases in the old performance framework and we will look to introduce either that or a similar measure. So, whilst that is outside the local health board's gift—that's why we try to keep it to reviewed—we will monitor the cases and ensure that they are being completed and closed.

[217] **Darren Millar:** So, there'll be clearer timelines, once a case is reviewed, for what happens next and what the timescales for those are.

[218] **Ms Dunsford:** Yes, but there will be additional guidance going out by the end of March on that.

[219] **Darren Millar:** Just one final point: given that the health boards are using Powys as a national resource, effectively, why shouldn't Powys just take on all of these claims in the future? Why do we need the local expertise, particularly if you can't rely on health boards in each of the regions to take the situation seriously—certainly, you haven't been able to in the past? They're not building their capacity up sufficiently well and you're having to kick their backsides more regularly than you ought to on this issue. Why shouldn't there be one national

lead on this—Powys—and it does all the claims if a CHC challenge is raised?

[220] **Dr Goodall:** I would hope for the future that, by health boards getting their local experience and expertise in place, it actually reduces the number that work through for the future. In that scenario, I'd be open to the fact that, possibly, they could be discharged through a national programme, but still with the support of the LHBs. I think at this stage, though, my focus would be to say that health boards still remain legally and locally responsible for these cases. It's about building up their own professional structure, the complex care experience, which allows them to process at this stage. The danger, if you revert to a wholly national process, is we still have many patients requiring to be placed in packages of care as part of the local facilities. But, given the success and experience of the Powys programme, it's clearly shown us that we can discharge at this stage. But, we do need to spread infrastructure across the individual health boards as well as for the current caseload that's in place.

[221] **Darren Millar:** I can appreciate people still require assessment, et cetera. But, it's one way of driving consistency, isn't it, to have one single decision-making lead, if you like, that then informs the decisions on the ground and helps to—

[222] **Dr Goodall:** But, even the current agreement that takes us through to 2017, at this stage, that will remain the premise for collective working across the health boards for the future. So, I wouldn't assume it just suddenly means the Powys programme comes to an end in 2017. We need to work that through on the basis of experience over these interim two years anyway, and we can make judgments at that time.

[223] **Darren Millar:** The uncertainty over the Powys project, by the way, has that led to members of staff from Powys departing? Have we been losing that expertise as a result of that uncertainty and the failure of the health boards to individually and collectively agree to subscribe to the business case and invest in it?

[224] **Dr Goodall:** Yes, some staff have left Powys, but equally, it's been possible to get staff back in as well. Where staff have been lost they've tended to go into other relevant areas within the complex care arena anyway, so—

[225] **Ms Dunsford:** There was concern, because, I think, until the funding was confirmed, inevitably staff were worried about their roles. So, some were lost, but now there's been agreement to the funding— I did speak to Carol Shillabeer yesterday, and they are now recruiting additional staff again. So, we do expect them to be fully up to capacity very soon.

[226] **Dr Goodall:** It's clear we need a much stronger infrastructure of professional eyes and pairs of hands across the whole of Wales, and to keep that, you know, under very close review.

[227] **Darren Millar:** Okay. Thank you very much. There are no further questions from any Members. That draws us to the end of this particular item. Very grateful, Andrew Goodall, Albert Heaney and Lisa Dunsford, for your attendance here today. You'll be sent a copy of the transcript of today's proceedings for correction if there are any factual inaccuracies and the clerks will drop you a note in terms of the additional information that you've agreed to provide during the evidence session. Thank you very much indeed.

[228] The committee agreed to go back into private session for our next two items, so we'll go back into private session and clear the public gallery. Thank you.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:43.
The public part of the meeting ended at 10:43.