Cynulliad Cenedlaethol Cymru
Y Pwyllgor Archwilio

The National Assembly for Wales
The Audit Committee

Dydd Iau, 21 Medi 2006
Thursday, 21 September 2006

Cynnwys
Contents

Aelodau o'r Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Mark Isherwood, Irene James, Denise Idris Jones, Carl Sargeant, Catherine Thomas.

Swyddogion yn bresennol: John Hill-Tout, Cyd-gyfarwyddwr, y Gyfarwyddiaeth Perfformiad a Gweithrediadau, yr Adran Iechyd a Gwasanaethau Cymdeithasol; Ann Lloyd, Pennaeth yr Adran Iechyd a Gwasanaethau Cymdeithasol; David Powell, Swyddog Cydymffurfio Cynulliad Cenedlaethol Cymru.

Eraill yn bresennol: Jeremy Colman, Archwilydd Cyffredinol Cymru; Paul Dimblebee, Swyddfa Archwilio Cymru; Elaine Matthews, Swyddfa Archwilio Cymru; Allison Williams, Prif Weithredwr Ymddiriedolaeth GIG Ceredigion a Chanolbarth Cymru.

Gwasanaeth Pwyllgor: Kathryn Jenkins, Clerc; Dan Collier, Dirprwy Glerc.

Assembly Members in attendance: Janet Davies (Chair), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Mark Isherwood, Irene James, Denise Idris Jones, Carl Sargeant, Catherine Thomas.

Officials in attendance: John Hill-Tout, Joint Director, Directorate of Performance and Operations, Health and Social Services; Ann Lloyd, Head of Department of Health and Social Services; David Powell, National Assembly for Wales Compliance Officer.

Others in attendance: Jeremy Colman, Auditor General for Wales; Paul Dimblebee, Wales Audit Office; Elaine Matthews, Wales Audit Office; Allison Williams, Chief Executive of Ceredigion and Mid Wales NHS Trust.

Committee Service: Kathryn Jenkins, Clerk; Dan Collier, Deputy Clerk.

Dechreuodd y cyfarfod am 1.31 p.m.
The meeting began at 1.31 p.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

[1] **Janet Davies:** Prynhawn da. Croeso i aelodau'r pwyllgor a'r cyhoedd i'r cyfarfod.

Janet Davies: Good afternoon. I welcome committee members and the public to the meeting.

[2] I remind everyone that the committee operates bilingually, and that headsets are available for the translation of Welsh into English, as well as to amplify the sound.

[3] Atgoffaf bawb i ddiffodd eu ffonau symudol a'u *pagers*, neu unrhyw ddyfais electronig arall, gan eu bod yn ymyrryd â'r offer cyfieithu a darlledu. Os bydd rhaid gadael yr ystafell mewn argyfwng, dylid gadael drwy'r drws agosaf atoch a dilyn cyfarwyddyd y tywyswyr.

I remind everyone to switch off their mobile telephones, their pagers, and any other electronic device, as they interfere with the translation and broadcasting equipment. If we have to leave the room in an emergency, you should leave via the nearest exit and follow the ushers' directions.

[4] Nid wyf wedi cael unrhyw ymddiheuriadau o ran absenoldeb.

I have not received any apologies for absence.

[5] A wnaiff Aelodau ddatgan unrhyw fuddiannau? Gwelaf nad oes unrhyw beth i'w ddatgan.

Are there any declarations of interest? I see that there are none.

1.32 p.m.

'Gwneud defnydd gwell o lawdriniaeth ddydd y GIG yng Nghymru'
'Making better use of NHS day surgery in Wales'

[6] **Janet Davies:** In our second item on the agenda, we will discuss the findings of the auditor general's report, 'Making better use of NHS day surgery in Wales'. Optimising rates of day surgery clearly has significant benefits to the patients undergoing surgery and to NHS Wales itself. It was of interest to Members when we recently discussed the auditor general's follow-up report on NHS waiting times. So, in this session, we can look in more detail at the extent to which day surgery is being carried out in Wales, and whether action has been taken to tackle the barriers that prevent rates increasing.

[7] I welcome the witnesses to the meeting. I will ask you to formally introduce yourselves for the Record.

[8] **Ms Lloyd:** I am Ann Lloyd. I am the head of the Health and Social Services Department and the chief executive of the NHS in Wales.

[9] **Mr Hill-Tout:** I am John Hill-Tout, the director of performance and operations in the Department of Health and Social Services.

[10] **Ms Williams:** I am Allison Williams, the chief executive of Ceredigion and Mid Wales NHS Trust.

[11] **Janet Davies:** Thank you very much. Welcome to you all. I will open the meeting by asking the first question, which relates to paragraphs 1.5 to 1.7 and figures 3 to 4 in the audit office report. Ms Lloyd, the number of day surgeries in Wales is lower than that in England and Northern Ireland. Can you give an explanation of why that might be?

[12] **Ms Lloyd:** I think that there are a number of explanations. I think that we have been slower in putting in the infrastructure, guidance and policy direction than in England. It was certainly an imperative in England many years ago that there should be this move to day surgery and that day surgery should be regarded as the norm rather than the exception. So, I think that that has contributed to it. I also think that, because we really did not effect sound performance management and the measurements to underpin it until 2003, it was actually quite difficult to measure how much work was done on a day surgery basis and to therefore start to move the agenda forward, although some improvements had been made. I also think that we were slower to engage the clinicians. It is fundamental that there is a change in the way in which clinicians work and the way in which they approach the provision of their services, if we are to move very steadily towards day surgery and out-patient procedures being the norm.

[13] There is a cultural issue in that we have to do far more work, based on good patient care outcomes and patient satisfaction, with our patients and our clients to advise them of the advantage of day surgery and to give them the confidence to regard that as the norm rather than the exception. However, I think that what we have been measuring here is a moving feast, because, between 1999 and 2005, a number of day-case procedures became out-patient procedures, and thus a number of day-case procedures no longer counted. One difficulty that we have in analysing what has gone on in Wales—and I am sure that they will find that this is

the case in England—is the definitions that we have used for day surgery and having the data streams to be able to capture what is happening in terms of the change in the way in which patient care is delivered. One thing that we are doing in the Welsh Assembly Government is reviewing completely the definitions of day surgery, what is and is not included, and how we capture the movement away from day surgical techniques, as such, to those procedures that are undertaken in out-patient departments or are just not undertaken in that way at all anymore. These are medically led interventions.

[14] **Janet Davies:** Right, thank you. That was an interesting reply. I will not start asking you about some of the detail, because I know—

[15] **Jocelyn Davies:** Janet, can I ask a brief question on something that was said about patients and the cultural issue?

[16] **Janet Davies:** Yes, okay. I will bring you back in a moment, Jocelyn.

[17] Is there any particular reason for us being slower off the mark in Wales? Is it perhaps down to having a different culture in the NHS in Wales compared with other parts of the UK?

[18] **Ms Lloyd:** I think that it was a difference in policy direction to deliver waiting times in England, as we know collectively, because we have discussed this before. That started a number of years before, and, in Wales, we quite rightly determined that we could move all the waiting times and lists that we liked, but unless we started to attack the fundamental problem of ill health, whatever we tried to do, we were on treadmill. So, the movement of trying to attack the problems and the causes of ill health was the policy priority, followed by how to treat patients better. Of course, that movement started in 2002 to 2003, with the emphasis on improving performance management in the service, knowing what they are doing and knowing what the standards are within the service. So, this whole plethora of policies has emerged from the 2001 ‘Improving Health in Wales’ strategy, which had improvement in performance as one of its main themes, coupled with an improvement in the health of the nation. That really started the change that we are now seeing.

[19] **Jocelyn Davies:** You mentioned cultural issues. Do I take it from that that there might be some resistance from some patients to having day-care surgery?

[20] **Ms Lloyd:** Extra reassurance needs to be given to patients about day-care surgery. We have to be clear that we can now manage much more complex surgery on a day basis, particularly on a surgical basis of 23 hours, 59 minutes. We have to be able to provide the evidence for people. Culturally, the sorts of questions that arise in the mind of a patient faced with day surgery are: ‘What happens if something happens when I get home and I am on my own? What is the follow up going to be and what back-up is provided? Can I even get home? Is someone going to be there to make sure that I am okay when I do get home?’. We need to be able to discuss this whole-system change with patients rationally so that they can make a proper choice and so that we can ensure that all the processes, including the social care processes and the community nursing service—everything—is put in place to respond to a different type of care provision.

1.40 p.m.

[21] **Janet Davies:** Thank you. Even within Wales, there are quite significant variations in rates of day surgery between the trusts. What are the main reasons for that?

[22] **Ms Lloyd:** There are several reasons. First, we must consider what priority and energy management gave to implementing any guide to good practice. It is obvious from the data in front of you that some organisations embraced this challenge and have shot ahead and

are producing some good, cogent results for day surgery services.

[23] In some places, there has been a lack of capacity. Despite all the will in the world, the facilities have not been effectively planned to deliver good day surgical services. You have to carefully think through the process of how a patient will safely be managed through this intervention—it is mostly, but not universally, through having dedicated facilities, hence the investment that has been made.

[24] There is also an issue of clinical engagement. When we set up the team with clinicians to produce the guide for good practice, many clinicians in Wales advocated fairly fundamental changes to the way in which surgery is done. However, that has not been universal. Some clinicians, justifiably, are not great advocates of day surgery. This week, we have met with representatives from the Royal College of Surgeons, again, to test their minds on the value and thrust that they can give to underpin the evidence that we and England have on the effectiveness and good quality outcomes of day surgery.

[25] There was also the issue of the sheer practicality of providing care. Usually, if patients live more than two hours away, you have to think carefully about whether the day surgery is appropriate, so it must be used in a sensible and sensitive manner. Again, there is a question of the dependence of the patient. You must adjudge whether or not you are dealing with a particularly ill population, whereby it is not just the surgical problem that needs to be solved, but a whole raft of other medically and socially orientated problems that affect that patient and which might deter you from offering them day surgery. So, there is a combination of reasons. However, management must work through that guide, which has been carefully and thoughtfully written, and see what is appropriate for its group of patients, because when you look at Wales—and, within the guide, it is quite clear—many other procedures are undertaken in Wales on a day-case basis and there are consultants who are keen to push out the boundaries of what is available on a day-service basis, particularly if we can capture the data up to 23 hours, because that gives them far more scope. However, we have to take the patients with us.

[26] **Janet Davies:** Thank you. I now turn to Ms Williams, because some of the factors that Ms Lloyd has mentioned are quite acute in your area. You have a rural area with some people living in isolated parts, and yet you have achieved the highest day surgery rates in Wales. Could you give an indication of how you have managed to do that?

[27] **Ms Williams:** It is a combination of culture and leadership, and that leadership has to be through the managerial and clinical aspects working in partnership. You need to have the clinical champions who believe in the benefits of day surgery and day treatments for patients. However, it is crucial that you also work across primary care with GPs, so that you fully understand the patients' needs before they present for their treatment, that you work closely with the district nursing services so that the back-up is there for patients, and that the pre-assessment process is very robust, so that you are screening out the problems that patients may experience if they have day surgery before they are ever elected to have that form of treatment.

[28] One of the real advantages of working within a small community is that achieving those cross-cultural, cross-boundary working relationships is easier. However, by the same token, you have patients who are travelling perhaps far greater distances, or patients whose infrastructure at home is not as good as you might otherwise find. However, I will show you an example of how we achieved a significant increase in our ophthalmology day-case rates by working with patients. Talking to patients, we found that the elderly-confused particularly were more distressed by the process of having to go into hospital, get undressed, go to theatre, and be in a recovery room. We found that it was enough simply to say to patients, 'You can go into theatre in your clothes with a gown on, all you have to take off are your shoes, you

will recover in a chair so you do not have to lie down in a bed, and you will be home this evening'. That shifted the expectations of both patients and their families so that we could achieve what we have achieved. However, it cannot be done in the guise of good practice alone; it has to be that together with a clinical championship and robust performance management.

[29] There is one additional benefit that my trust has had over the last few years, which is that we have been part of the CHKS UK-wide benchmarking group. As part of that, we have published, by consultant, the day-case rates for the last five years. Peer pressure is a tremendously effective tool to get people to reflect on their own practice. When you are not benchmarking just within your own organisation but with the best across the UK, that is a huge incentive. Ceredigion has been in the top 40 hospitals for the UK for the last four years.

[30] **Janet Davies:** Thank you very much. Could I bring you in now, Mark?

[31] **Mark Isherwood:** Yes. I refer you to paragraph 1.9, figure 5. My question is for Mrs Lloyd. Of the 25 procedures that the Audit Commission has identified as capable of treatment as day cases in 75 per cent or more of cases, only five achieve that rate in Wales compared with nine in England. Why were the day surgery rates so low in some of those procedure areas?

[32] **Ms Lloyd:** I outlined the problems that we face in implementing consistent day-surgical procedures across Wales. Those organisations where there was, as Allison described, this synergy between the clinical and managerial leadership in order to promote day surgery have made the most progress. However, with a number of day-surgical procedures, over the past two years, evidence has shown that these are not best provided generally on a day basis. For example, the number of tonsil and adenoid cases treated on this basis is low, because you will recall the problem that we had with reusable instrumentation. The clinicians did a lot of work with us on what was most suitable. So, the number and range of day-surgical procedures is altering almost daily, as more and more work is done on finding alternatives to the provision of day surgery. That is where the emphasis was placed by the clinicians and the management, in terms of the practicalities of implementing day surgery more widely. I also think that some of these organisations have not really had suitable facilities to be able to promote day surgery more effectively. I am sure that we will come to that later on, when we can discuss what we have done about it.

[33] **Mark Isherwood:** Given that you have just said that the basket of procedures is a moveable feast, is that information being discussed with the Wales Audit Office so that it can be updated?

1.50 p.m.

[34] **Ms Lloyd:** The auditor general can speak for himself, I am sure, but the audit office has adhered to its basket. I do not know, but, given the range of procedures outlined in our guide, which will be updated year by year on what is done on a day-case basis, and what is now no longer being done on a day-case basis but on an out-patient basis from that basket, we can have that sort of discussion with the auditor general. The work that has been done in this report is extremely helpful when one takes it in conjunction with our modernisation audits. We need to be able to move with the times.

[35] **Mark Isherwood:** Moving on to the fact that one of the big successes of day-care surgery was cataracts, the report refers to an improvement from 61 per cent to 91 per cent between 1999 and 2004. How was that achieved by the trusts, and does this point to any lessons for day surgery in general?

[36] **Ms Lloyd:** It was established by a very precise target being set by the Minister, which was a six-month target for cataracts. The evidence available to us was that cataracts were one of our major problems in Wales and really needed to be attacked, and that we should very much improve the service. A lot of resource was put into the initiative and the facilities required, and there are some very good dedicated cataract and ophthalmology day-unit facilities in Wales.

[37] **Mark Isherwood:** I know that subsequent questions will relate that to other treatment areas, but I will now move on to put a question to—

[38] **Janet Davies:** Before you go on to the next question, Mark, I will ask Jeremy to come in. Do you wish to say something, Jeremy?

[39] **Mr Colman:** Simply that the references in my report to the Audit Commission basket are indeed correct. It is an Audit Commission product, not a product of the former Audit Commission in Wales, so I have not inherited the basket. It seems to me that there is some merit in there being a basket, and for that basket to apply in England and Wales, and I hope that, in future, we will be able to work with the Audit Commission, rather than produce our own Welsh version of the basket. That would be useful to develop. However, as Mrs Lloyd's evidence has brought out clearly, the contents of the basket need to change all the time, because of changes in what clinicians believe to be appropriate. It is quite a tricky thing to do.

[40] **Jocelyn Davies:** Are we not just making a direct comparison between Wales and England with the same basket?

[41] **Mr Colman:** Yes, exactly. That is quite right. It is the Audit Commission's basket that we are using, not—

[42] **Jocelyn Davies:** So those things change in England as well?

[43] **Mr Colman:** Indeed, they do.

[44] **Jocelyn Davies:** At the same time as well, so this is just a direct comparison.

[45] **Mr Colman:** The comparison is absolutely valid. The question is whether the basket is completely up to date, and it probably is not.

[46] **Ms Lloyd:** In addition, we need to have discussions with the Royal College of Surgeons and its day surgery expert group about whether it is time to revise this.

[47] **Jocelyn Davies:** Yes, but my point is that this is a direct comparison. This is an apples-with-apples comparison, so you cannot say, 'Well, we are not doing as well because some of these things should not be in there', because it is a direct comparison with exactly the same thing in England.

[48] **Mr Colman:** It is an exact comparison; nevertheless, it may not be the right comparison, because the basket is inappropriate in both countries.

[49] **Alun Cairns:** It is the same for them as it is for us.

[50] **Janet Davies:** Okay, I think that that is now clear.

[51] **Mark Isherwood:** I will just say that we would need to know whether those four particular procedures, where England achieved the target and Wales did not, were situations where, in England, the people presenting themselves were a different or similar proportion of

the population. If they were similar, what actions have been taken to look at the good practice established in those particular areas?

[52] I now put a question to Allison Williams, which is on the good news about cataracts. You have done particularly well on these figures, showing a 40 per cent increase from 56 per cent to 96 per cent. What actions did you take to achieve that?

[53] **Ms Williams:** There were a number of factors, including improved pre-assessment, working with patients and the scheduling that goes hand in hand with that. Particularly with the elderly, which this group of patients tends to be, scheduling the time of day that they will have their day surgery procedure according to their other health needs and their normal patterns and behaviours is instrumental in achieving compliance with day case.

[54] The second issue is technical, because the actual instrumentation and some of the surgical techniques have improved over the past three or four years as well. Certainly, in Ceredigion, we do not use anaesthetists any more to do the blocks for patients. The surgeon gives the block anaesthetic and conducts the surgery. It is a perfectly safe practice, perfectly governed and authorised by the relevant royal colleges. However, that improves the entire patient experience. Patients have their surgeon doing everything, in terms of their care.

[55] The third issue is nurse-led discharge. We do not have systems in which patients have to wait in hospital for the doctor to come back to discharge them. If the patient meets the clinical post-operative parameters, the nurses can discharge them and send them home in a planned way. The doctors do not usually need to come back to review the patients unless they are required to do so, and that has also speeded up the process.

[56] Finally, there is pain management. Cataracts represent the one area where pain management is probably of least significance. However, you have to get it right. You have to address it pre-operatively, working with patients on their normal pain management and normal pain thresholds, and let them know that there is a 24-hour telephone number that they can call if they are worried. That is also instrumental in giving patients the confidence to go home a couple of hours after their surgery, knowing what pain they can expect, what pain relief they can use, and that they can pick up the telephone if they are in trouble or worried.

[57] **Mark Isherwood:** Thank you. I will allow colleagues to question on the broader picture.

[58] **Denise Idris Jones:** If we look at paragraphs 1.9 and 1.10, and at figure 6 on page 18 of the report, we see that it explains how the increases in overall rates of day surgery have been primarily driven by the increased day-case rates for cataracts. Mrs Lloyd, when cataract procedures are excluded, the improvement in day-case rates between 1999-2000 and 2003-04 was less half of 1 per cent. Why have trusts failed to improve performance in the other 24 basket procedures?

[59] **Ms Lloyd:** There is a variety of answers to that, which will vary from place to place. Some of it will be down to the facilities that they have, some of it will be down to their own leadership with their clinicians, about changing the way in which they deliver care, and some of it will be about reassurance for patient groups with regard to the efficacy of the outcome of day surgery and what it means for them, and whether they will be safe—all things that worry patients. That is why the Minister has increasingly emphasised, since 2003-04, the necessity to improve day-case rates in Wales, and to instil a culture in which the question has changed from, ‘Is this a day surgery case or not?’, which might diminish its importance, to, ‘Is there any reason why this should not be undertaken as a day case, and are there any barriers to that?’.

[60] Another problem that we have, particularly in Wales, is with the definitions, because you can have limits on what counts as a day patient. If, for example, you have an afternoon list and, by the time the day surgery unit closes at 6 p.m. or 7 p.m., the patient is not fit for discharge and is therefore kept in overnight, that person is not then counted as a day case, even though he or she may go out in under 24 hours. That is why we have the central information team working on this, looking carefully at the definitions that we use for day-case surgery, so that we capture everything that is actually done as a day case. I do not think that they have solved that in England either yet, but you know all about the information systems there. So, I think that there is some of that, but I also think that we need to place far more emphasis on ensuring that the clinical champions are allowed to effect a change in how care is provided, and that we have more emphasis on the clinical teams and the management placing their full weight behind changing the model of care.

2.00 p.m.

[61] **Denise Idris Jones:** That was very informative for me. My mother was in hospital last week and she was supposed to be a day case. It is culture that we are talking about here, because she has been a day case many times but she likes to go in for three days. It is because of the culture of the matter. It shows a lack of communication; her GP had not spoken to her about this. We need to do this with our older generation, especially in a constituency such as mine, Conwy, where so many older people live. So, I think that what you said was very important. My mother did go out within two days, but she still felt that she needed another day to ensure that she had received a proper ‘service’.

[62] My next question is to Allison Williams. When cataract procedures were excluded, your trust increased its rates of day surgery between 1999-2000 and 2003-04 by 6 per cent, which is significantly better than the average across Wales but substantially lower than the increase for cataracts. Can you explain why rates for the other basket procedures failed to improve as significantly as for cataracts?

[63] **Ms Williams:** Again, the reason is twofold. One reason is that we were focusing at the time on cataracts and getting that right first, and learning the lessons from the whole experience of improved performance in cataract surgery. If you look at our data for the end of last year, we were achieving 80 per cent day-case rates in the majority of procedures within Ceredigion. That was focused around much more effective pre-assessment and managing the expectations of patients. Sometimes, even in rural areas, that means that people go home at 8 p.m., but that is okay if it is pre-planned, the transport is in place for them and the expectation has already been raised. The whole concept that you will be home by bedtime and be able to sleep in your own bed is very powerful when you work with patients. In the early days, the drive was around cataract surgery and the lessons learned from that have meant that we are catching up across the whole range of day-case procedures that we do in Ceredigion.

[64] **Denise Idris Jones:** Good, thank you.

[65] **Leighton Andrews:** Paragraph 1.11 talks about increases in day-case rates since the acute hospital portfolio audit in 2003-04. It suggests that there has not been much evidence of significant improvement in day-case rates. What will it take to make this happen?

[66] **Ms Lloyd:** Given these type of results, we had to take some action from the centre. Therefore, we did a couple of things—well, more than a couple. The first thing was that the Minister included in the service and financial framework targets and efficiency indicators for 2005-06, in particular, that trusts should meet for those procedures which were either of the greatest volume or, when it came to bunions, which we are probably going to exclude for the next year, where there was so much variation and poor performance. However, there is a big discussion going on about how appropriate that type of surgery is on a day-case basis. In the

2006-07 service and financial framework efficiency target, there is an action, whereby, if, by December 2006, trusts do not make a significant improvement in the way in which day-case surgery is undertaken and have no cogent explanation for that, we will send in the delivery support unit, which will work, as it did with Swansea last year, on a day-by-day basis with the trust—it is a group of national experts—to improve its processes and techniques, and work with its clinicians and managers to ensure that data is captured properly and that patients have all the requirements of support to enable day-case surgery and its outcomes to improve.

[67] I have also asked that a modernisation audit be undertaken by the National Leadership and Innovations Agency for Healthcare, based on the 10 enablers to change practice that were produced by the modernisation agency in England, and our guide to good practice in day surgery. Those modernisation audits arrived on my desk on Monday—one for each organisation, including each local health board—for me to see where they had got to. The first of the enablers is an improvement in day surgery. I have only had a cursory glance at them; I want to devote far more time to them before I make any pronouncements, but some organisations have been doing very well indeed. Others are still lagging behind and we have asked the leadership agency to put its improvers into those organisations to ensure that they get the best chance of making a definitive change in practice by the time that we get to December. Otherwise, if they continue to fall behind, the delivery support unit will go in.

[68] Obviously, we are using the Wales Audit Office report in conjunction with those modernisation audits because that gives us a very good suite of evidence and information to work through with organisations, to enable them to improve. The leadership agency is also promoting clinical leadership and is running a number of events and functions around Wales as part of our agreement with it for this year and the next three, to enable the clinical leaders to come forward. We are working again with the Wales day-case expert group on how we can continue to promote good practice, particularly the good practice that is not included in the basket but which has been developed over the past three to four years. So, a huge emphasis is being placed on the need to improve day surgery appropriately in Wales.

[69] **Leighton Andrews:** Appendix 7, page 93 shows that only Ceredigion hit all the targets in the south, and the area where the majority of trusts seemed to have made an impact was cataracts. Was that because of other priorities laid down by the Government in respect of cataract waiting lists?

[70] **Ms Lloyd:** These are the priorities now. They have been clear for the last two years in the service frameworks and that is why the intervention has been escalated, not only to undertake these modernisation audits, which I do not think the service expected, but to then allow NLIAH—the National Leadership and Innovation Agency for Healthcare—and the delivery support unit to go in to support the meeting of those targets.

[71] **Leighton Andrews:** Sure. Sorry, my question was: is the reason why the area of cataracts seems to be ahead of the others because there has been a focus on cataract waiting times in the waiting times initiative?

[72] **Ms Lloyd:** Yes, it is—for a longer period of time.

[73] **Leighton Andrews:** Okay.

[74] **Mick Bates:** Moving on to pages 20 and 21, starting with the statement at the top, we see that it says,

‘Performance measurement systems may not reflect best clinical practice and are inconsistent’.

[75] Clearly—this question is for Ann—there are difficulties in the way that day surgery performance is measured across Wales, and you have already outlined some of the issues. How confident are you that you have the right systems and access to the right data to enable you to have a full understanding of day surgery performance in Wales?

[76] **Mr Hill-Tout:** Is all right if I take that question, Chair?

[77] **Janet Davies:** Yes.

[78] **Mr Hill-Tout:** The report indicates that there are several different ways to measure changes in clinical practice, so, currently in Wales, we measure day-case work in the traditional way, which is, if a patient is admitted and discharged on the same day, that is a day case. However, the report rightly refers to the fact that, as clinical practice changes, shorter lengths of stay, such as 23-hour-and-59-minute lengths of stay, might be appropriate clinically but might not be classified in the traditional way as a day case. So we have recognised that we must ensure that the measurement systems that we have are updated and accord with changing clinical practice. So, one of the issues that we have addressed as a department is how we set the definitions of all of the corporate and health information that comes in. A working group is currently looking at seeking to amend the definition of day cases so that we have those cases that are admitted for the day but so that we also have the 23-hours-and-59-minutes definition clearly stated. That will address those clinical conditions that are capable of stays of a 23-hour-and-59-minutes period.

2.10 p.m.

[79] That particular work is ongoing and we hope and anticipate that we will be issuing new definitions in the new year. That will tighten the performance measuring system. The other effect that it will have is that it will engage clinicians in the way that my colleagues have been talking about. It will engage clinicians much more because they will recognise the legitimacy of the practice. At the moment, if a clinician offers treatment for 23 hours, but then discharges the person on the next day, he is not counted as having admitted a day case. What we need to do is reflect clinical practice in our measurement system and I think that that is what that point is about. We are actually addressing that at the moment.

[80] **Mick Bates:** If I may précis that, you are going to standardise the measurement of day surgery performance in Wales.

[81] **Mr Hill-Tout:** We are.

[82] **Mick Bates:** Will that work be complete in January?

[83] **Mr Hill-Tout:** We have a working group that is looking at that now and we are hoping that we can complete that work in the new year.

[84] **Mick Bates:** Fine. As you are aware from the report, there is considerable confusion over this and I think that Bro Morgannwg has a short stay and an overnight measurement.

[85] **Mr Hill-Tout:** It has.

[86] **Mick Bates:** Within your standardisation of the measurement of day surgery, will you be making recommendations about how trusts could achieve the new definition?

[87] **Mr Hill-Tout:** Yes, indeed. That is absolutely right. We can follow up the support that we give to trusts through our guide to good practice, through NLIAH. When we set up a measurement system, we need to ensure that we help trusts to understand how that fits in with

the new system and provide that support. We will do that.

[88] **Mick Bates:** This is the $64,000 question, Allison. As a chief executive, what do you think the Assembly Government should do to ensure consistent recording, reporting and analysis of day surgery performance?

[89] **Ms Williams:** It is the $60 million question. I think that the Assembly Government cannot do anything in isolation; it has to be done working with the service. Accountability, in terms of my organisation's performance, stops with me. The Assembly can give me the guidance and the parameters to work within, but unless I am prepared to performance manage my organisation, and my staff within that, to deliver, then it is only as good as the paper that it is written on.

[90] What I think will be extremely helpful are two things that are related and are both coming on stream imminently. One is, as John has described, the new guidance around the definitions, because you can, ironically, have in-patients with zero length of stay within our current definitions because they are not in for 24 hours. Therefore, are they in-patients or are they day cases? The definition will be extremely helpful. The other thing that will be extremely helpful, and which the Welsh Assembly Government has already sponsored and funded, is the new system linked to the consultant contract for performance monitoring and performance management of consultant staff, linked to appraisal. By 2008, that process will be in place in its entirety, but much of the data are already available and can start to be used for individual appraisal as early as next year. That is, individual consultant day-case rates and, when the definition is in place for 23 hours 59 minutes, individual consultant rates for that, by specialty and by procedure. That will mean that we can begin to really drill down, consultant by consultant, procedure by procedure and then target action. However, as I said, this will only work with a partnership between the service and the Assembly because the guidance without the performance management will not achieve the outcomes.

[91] **Mick Bates:** Could you expand a little on how you, in your trust, monitor and manage day surgery performance?

[92] **Ms Williams:** As Ceredigion has been part of the CHKS benchmarking group for several years, we have been monitoring by procedure, by consultant for several years. The difference with the new consultant contract is that, at the moment, the data is anonymised, so I know that it is not made public. Within the new consultant contract monitoring information, that will be open and consultants will be able to compare with each other and the public will also be able to look at that information, which in itself will be very powerful.

[93] **Mick Bates:** Finally, when you mentioned data, you said that most of it was available. In which areas are the data absent?

[94] **Ms Williams:** The compass system for consultant contract performance monitoring has a number of qualitative and quantitative indicators within the programme. Some of the definitional work around the qualitative indicators is still in development and that is going to be piloted and tested over the next 12 months, but the quantitative data is available within our information systems now and when some of the definitional issues to which John has referred have been refined, it will give us another layer of performance management information that will help the accountable chief executives to ensure that performance is improved.

[95] **Ms Lloyd:** We can circulate a copy of the proforma, if that would be helpful to you.

[96] **Mick Bates:** It would be very useful.

[97] **Janet Davies:** Yes, we would be very grateful.

[98] **Ms Lloyd:** It is unique within the United Kingdom; we have delivered and developed it ourselves.

[99] **Janet Davies:** We would be very grateful if you would do so, Mrs Lloyd. Before I go on to Carl and on to part 2, I will ask you one question. Clearly, there are challenges affecting management and leadership in different parts of Wales, but it seems that the challenges when the clinicians do not feel that they can support day surgery are perhaps more profound for various reasons. That involves their professionalism, their training and having to change as time goes by. Do you think that it is their background and training that makes it more difficult for them to be pro day surgery or is it more the case that they feel that they do not have the confidence that the support measures are really robust?

[100] **Ms Lloyd:** I think that it is a mixture of all of that. You have the absolute advocates, with clinicians travelling abroad to see whether or not they can do laparoscopic hip replacements these days. So, you have the clinicians who will challenge the evidence so far and see what alternatives can be used. But, I think that an awful lot of it is to do with whether or not the consultants feel confident that they have had the opportunity to review and revise their skills in order to be able to deliver it, and whether or not they have the confidence that the support network that has to be in place in order to have successful day surgery outcomes is there in their organisation. The consultant contract should, I think, very much help with this constant moan from clinicians that they have always been doing the day job and never had time to refresh their skills or whatever. Under the new consultant contract, up to three sessions a week are put on one side for them to do training, education, research and whatever it is that would enhance their clinical prospects. I think that we have to continue to discuss with the chief executives the importance of all their clinicians being given the opportunities to acquire all of the skills that are necessary to keep up with modern practice.

[101] I think that the benchmark comparisons, which Allison has referred to within the consultants contract, will start to highlight some of the differences, but I think that clinicians, like any other practitioner, need to be convinced. They also need to be in the lead, challenging the management and the systems to change. We need to be able to galvanise that enthusiasm. There are many very enthusiastic, hard-working clinicians in Wales, who have eagerly embraced day surgery and are pushing out the boundaries, hence the change in day surgery procedures over the past five years. We need to be able to ensure that we are giving them—and their teams—sufficient space and time to change practice, where that is relevant to them.

[102] **Janet Davies:** Thank you very much. We will now move on to part 2. Carl?

[103] **Carl Sargeant:** Thank you, Chair. Before we move on to part 2, may I follow on from Mick's question about the 23-hours-59-minutes ruling? Is that a little bit of a con? Most people who think that they are going in as a day case think that they will be in and out in a day. Is this just a way of manipulating figures to create another day? It is actually overnight, so is this just another way of calling it a day? It is actually a two-day case, is it not?

2.20 p.m.

[104] **Mr Hill-Tout:** I think that it is about reflecting what is clinically appropriate. You have to see it in the context of how care is shifting from a five or six-day stay in hospital to much more care in out-patients and in the GP practice. So, we see conditions moving from a traditional day-case unit into out-patients being treated in outpatients. We then see single day-case admissions, 23 hours 59 minutes. In 'Designed for Life', we have set a target that we want to see the majority of all patients only in hospital for 48 hours. I do not think that it is a con. It is about trying to agree measures, which are accepted by the health community in England, Wales and elsewhere, to reflect clinical practice. If we do that, we secure the

treatment that the patient needs, but we also engage consultants and other senior staff, because they see these measures as meaningful to them.

[105] **Ms Williams:** Chair, may I add to that? This also refers back to the 4 p.m. day-case procedure. It is important that, if we are going to get best value out of our facilities, we need to be using them all day. It is easy to see that a day case is someone who has a procedure at 10 a.m. and is discharged six hours later. However, if someone is having a 4 p.m. procedure—in order to get the best use out of our theatres—to discharge them six hours later, particularly if they are elderly, is very difficult. So, to keep those patients, in what you would call a patient hotel or a hospital bed—essentially, they are sleeping in hospital so that you can discharge them in a humane way first thing the following morning in a planned way—is not cooking the books by anyone's definition. It is actually making the best use of our facilities. It is not straightforward, that is how the clarification around these data definitions is going to help chief executives like me to ensure that we are managing that appropriately, but that we are also meeting patients' needs.

[106] **Carl Sargeant:** My point was not about cooking the books; it was about the patient being the important issue. The fact is, if people are going to be in hospital for two days, as opposed to a day case, then they have to be told that. That is a measurement. It may be a clinical measurement, but in public it is perhaps not seen as quite the same. That is an important aspect. If we drop the measurement of day case and tell people that they may be in overnight, people will accept that, but it could be a little misleading for measurement.

[107] I will move on to part 2 on the barriers to increasing day surgery rates in Wales. The document, 'A Guide to Good Practice: Day Surgery in Wales', was not issued as a Welsh health circular. How could the National Leadership and Innovation Agency for Healthcare day surgery programme achieve a broader impact on day surgery practice?

[108] **Ms Lloyd:** There are two things there about why we did not issue it as guidance. You learn by what happens. The thing about the guide to good practice, as with a guide to any good practice, is that we must not forget that, as I think Allison has said, the chief executive of an organisation is charged with delivering an operational service in the best interest of patients. Therefore, if you do produce good practice, which has been very well researched and is owned by the clinicians and the managers who are going to have to deliver it, then my anticipation is that chief executives will implement that guide to good practice, unless they have a very good reason not to do so. The very good reason would be that they are already doing it and have moved on even further.

[109] So, it was hugely frustrating, when we started to get the results coming back from the audit office, and our own results, to find that the progress that could have been made, had not been made. So, we have to stand back on our views of the guides. I would expect guides to be warmly received by chief executives and their boards, and implemented with their clinical teams in the lead, but if that is not going to take place, then one has to impose a little more. That is what we are considering at the moment with the other suite of guides to good practice that we are going to be asking NLIAH to develop for us as a community, including the health service in Wales. I cannot remember the second part of your question, I am sorry.

[110] **Carl Sargeant:** How could the NLIAH day surgery programme have achieved a broader impact on day surgery practice?

[111] **Ms Lloyd:** As Allison said, in order to make improvements at the centre, the Welsh Assembly Government and the service have to work together. That is what we aim to do. However, we also learnt a lesson that we had to have better performance-management systems whereby this became an important target, which should be achieved. That is why, over the past two years, you have seen an increasing emphasis on the importance of day

surgery in terms of how care can be delivered within the service. More people can be treated in Wales, as is shown so clearly in this report by the auditor general. That is why the Minister asked us this year to place a deadline of December 2006 for improvements to take place or there would be intervention. That is the first time that he has made that so explicit in a circular to the service on its performance and delivery. We must learn that just issuing guidance is not embraced with quite as much enthusiasm by some as it is by others. There might be many reasons for that, but if it is important for patient care in Wales, and if more people can be treated well with good outcomes from changing practice, then we have to ensure that we have the performance-management system to ensure that that is taking place. We must also provide the help to enable organisations to change.

[112] **Carl Sargeant:** Do you believe that you can now identify failings in the system through your recording system as opposed to issuing guidance to your trusts that would include stronger words? It is clear, in this report, that there is variance between hospitals and delivering performances. That is quite shocking in some areas. We must be robust about that. So, do you have that data now?

[113] **Ms Lloyd:** Yes. The modernisation audits and this data from our auditor are fundamental to pinpointing those differences between organisations. That allows NLIAH, as the improvement agency, to enable people to help the clinicians, managers, whoever—the whole clinical team—to adopt best practice or for the DSU to go in and ensure that there is improvement after December. We can always improve, but those two pieces of intervention, in particular, together with the performance management that takes place monthly at my committee, are the three planks that will allow us to improve.

[114] **Carl Sargeant:** Mrs Williams, are you satisfied that your trust followed fully the guide to good practice?

[115] **Ms Williams:** Yes, and I think that one of the advantages of the guide to good practice is that it offers flexibility for local application, depending on local circumstances. There are so many great variations in the availability of equipment, facilities and so on, that if it were very specifically mandated, some well-performing organisations would struggle to meet the guidance. The key for us is always how we continue to strive for improved performance within the framework of that guidance.

[116] On the reporting mechanisms that we have for performance management within our organisation, we have a balanced scorecard reporting system in NHS Wales. We have to report monthly to our boards on the achievement of those targets, in line with the good practice, and that is reviewed on a quarterly basis by the regional office. So, there are systems and processes in place to make the connection between performance and reality.

[117] **Alun Cairns:** Appendix 7, on page 91, sets out the targets and seven specific procedures along with the performance of each trust against those. Bearing in mind that 75 per cent of day-case targets has generally been accepted for many years, why are the targets in this spreadsheet less than 75 per cent?

[118] **Mr Hill-Tout:** We made a decision three years ago that, in addition to presenting targets for service delivery to the Minister, we would introduce efficiency targets for the NHS. Over the last three years, we have systematically tightened those efficiency targets. We introduced the day-case efficiency targets around two years ago and these targets, as you see are less than the 75 per cent.

2.30 p.m.

[119] We took a view, and we can debate that view, that, because the service was at a

particular point in its performance on day surgery, we would need to put targets in place that would allow improvement in systematic annual increments. So, we took the view that we would be strengthening our performance management system and giving efficiency targets, and that it would probably take more than one year to get to the 75 per cent in all of the areas and in all of the trusts. Therefore, we calculated targets that we thought were achievable for those individual organisations. Now is the time to do this, and the auditor general's report refers to the fact that we are developing a more comprehensive suite of efficiency indicators, which will require the NHS in Wales to achieve a universal set of targets. That is about development. However, the view that we took at the time was that we should have an incremental movement based on the performance of trusts, as they were at that time.

[120] **Alun Cairns:** Let us take your argument a little further. The logical step is to ask about those trusts that perform particularly poorly; will they still have their targets increased, or will you leave them at a lower level?

[121] **Mr Hill-Tout:** We will monitor closely those trusts that need to make the biggest improvement. So, when our annual targets are issued to the service in December, for next year, there will be one single target to be achieved by all organisations.

[122] **Alun Cairns:** So, that is an admission that you were wrong in the first place to have more of a local target.

[123] **Mr Hill-Tout:** You can have a debate about that. This was a view that we took based on the evidence at the time and our knowledge of performance management improvements. Not all organisations are able to achieve the optimal level in one year. We took the view that it was appropriate to set interim targets, as we have in other areas. You then get to a point at which you are satisfied that the NHS can have a single universal target. If that is an admission, then we certainly thought that that was a sensible thing to do.

[124] **Alun Cairns:** I am still trying to tease out the logic of that. If a trust did not improve in a certain area, despite those interim, or soft, targets being in place, and you are now increasing the target, what hope do we have of getting them to the higher target and the 75 per cent universal target?

[125] **Mr Hill-Tout:** The setting of targets is one part of the equation. The other part of that is strengthening the performance management system—

[126] **Alun Cairns:** Excuse me for interrupting, but if they have not moved from where they were, then they will not achieve the higher target.

[127] **Mr Hill-Tout:** I dispute that. We are saying that we have learned that performance management is about having a support agency as well as me having an interface with an organisation and asking, 'Why have you not done something that the peer-group information says that you should have done?'. Over the last two years, as we have tightened performance management in Wales, we have learned that we need to deploy the specific help of experts into those organisations that are struggling. As Mrs Lloyd said, the delivery support unit—and we talked about this in the context of the waiting times report two or three months ago—specifically goes into organisations that are struggling. So, there is logic, in the sense that we have given those organisations at the bottom of the performance table that additional help. We then expect them to improve over the period of a year, or maybe a little longer—in the case of Swansea, the DSU has been working there for 18 months. We have taken the view that it is time to set a universal target, which is where we are for the next year.

[128] **Alun Cairns:** I will continue to direct questions to you, Mrs Lloyd, but, obviously, it is fine if you want to use Mr Hill-Tout. The 'Innovations in Care' document takes the

argument that day surgery should be the default position. Do you think that that is widely accepted by all trusts and clinicians? Is that their starting point and, if there is then a clinical reason that it should not be a day-care treatment, should they move from that?

[129] **Ms Lloyd:** No, I do not think that that is where we are at the moment. That is why the issue of clinical engagement is vital. Part of the work of NLIAH, as a consequence of its guide to good practice, which came out last year, is to better engage with the clinicians and the medical directors and so on, in terms of ensuring that it becomes the default and that the principles within this guide are implemented throughout Wales. However, even with this limited basket that we have been measuring over the past two to three years, we, with our clinical advisers, have questioned whether or not some of those procedures should still be regarded as mostly day-case procedures. For example, there is the issue of varicose vein stripping and ligation; we have stopped undertaking cosmetic procedures within Wales, and, therefore, the numbers of patients who now require an intervention of that sort are of a different character to the vast numbers that we saw before. So, we must use all these indicators sensitively, based on the latest clinical evidence.

[130] However, the chief executives and their teams and we need to do a great deal more work to ensure that those who are enthusiasts can be helped to enthuse others, and that all our clinicians have the ability to acquire the necessary skills to do this. Often, very different techniques are used to enable day surgery to take place, and we have a long way to travel.

[131] **Alun Cairns:** You have partly answered the next point that I want to raise, but how will you develop the performance management framework to encourage more widespread use of day surgery?

[132] **Ms Lloyd:** We have focused on what we think is possible. In terms of the waiting times initiative, going up to 2009, we have based the detailed planning from each organisation on their estimation of the progress that they will have made on the provision of day surgery, not just in terms of these 25 procedures, but right across the board. So, there is increasing evidence and an increasing necessity for those boards and their clinical teams to have a thoroughgoing discussion about how they will implement better day surgery rates across the board in their organisations, in order to meet the targets that have been applied to them. So, it is an ongoing discussion.

[133] **Alun Cairns:** Mrs Williams, how do you think that the service and financial framework targets and the performance management framework could be used to encourage better day surgery performance? What would influence you?

[134] **Ms Williams:** Until you get them down to an individual level, and you are talking about individual performance management, the ability to use those tools on a collective basis is greatly weakened. You must look at it on an organisational and a whole-system basis, together with managing individual members of staff.

[135] We must also recognise that most surgeons want to operate; that is what they want to do. As a management system, we must make this work so slickly and efficiently for them that it hugely incentivises their practice. We should make it possible for them to come into a day surgery unit and almost stand there, and the patients would arrive and they could operate. We must give them the tools to make that work for them. The tools are not just about facilities, but about systems and processes that make the default position that you referred to earlier preferable to them. They are not concerned about whether they are going to have a bed for their patient, an anaesthetist for their list or a theatre team. We must work in that partnership way, and the performance management at an individual level significantly helps that.

[136] **Alun Cairns:** Thank you for that. Clearly, the local health boards have an important

role, as commissioners, to ensure that day-case surgery is taken as the starting position. Mrs Williams, what approach did your LHBs take in terms of encouraging or facilitating you to achieve your goal?

[137] **Ms Williams:** If I am strictly honest, the performance improvements have probably been provider-driven until now. We are looking at different mechanisms of introducing commissioning levers into the system in the NHS in Wales, which I am sure will be hugely instrumental in the future performance of organisations. However, at the moment, our commissioning and our currency for activity could, in a perverse way, disincentivise day-case performance, because, as you move work from in-patient care to day-case care to out-patient care, unless your commissioning structure and your currency keep pace with that, you are not going to get the best outcomes. So, until now, I believe that it has been very much provider-driven, but I suspect that, if we were to find ourselves sitting here in two years' time, it would look quite different, and the commissioning levers will really start to bite, and will be another dimension to performance management.

2.40 p.m.

[138] **Alun Cairns:** Thanks for that answer. Mrs Lloyd, the LHBs' approach has been different, and it is quite startling to hear the responses to the Wales Audit Office's survey of that approach. How should they use sanctions or encouragement, and what should you be doing to ensure that they are doing it?

[139] **Ms Lloyd:** Fundamentally, they need to become more expert at commissioning care. They need to commission based on concrete evidence of best practice. We have been very well aware, since the local health boards came into being a couple of years ago, that the commissioning skills for them—and, indeed, right throughout England—have not been as well honed as they need to be, and that the skills and techniques for commissioning were largely laid to rest 20 years ago, throughout the UK. So, we started to work with the local health boards nine months ago to look at how we could re-energise commissioning, because it is fundamental to changing the way in which care can be delivered. They are the ones with the money, and they are the ones with the mandate to acquire the best range of care to meet the needs of their populations.

[140] So, what could we do to give them the skills, particularly in terms of secondary care, where we need to make a move, not just from in-patient care to day-case care to out-patient care, but from hospital care to community care? We decided that there needed to be a strengthening of the skills that were available to local health boards in order to do that job. A discussion/consultation is currently under way with the service, because you cannot do it just on your own, about the establishment of a greater skills base, regionally—or, in the case of the south-east, probably over two areas, which would make sense—in order to have a regional commissioning unit, which would undertake the contracting of services, with better value for money and more concentration of skills. Gwent local health boards have undertaken a pilot—and Cardiff has now joined in—to look at how best they can work with a provider, or a range of providers, to change the balance of power between commissioning and provision, and to describe better the range of their populations' needs and what they require from the provider. That has been quite successful. That particular pilot has been led by Torfaen, and it has had some considerable success in starting to refine the way in which commissioning is undertaken.

[141] However, in Wales, we regard commissioning as a real skill, and it should be recognised as such. We have therefore been working with NLIAH to look at the types of qualification and training that we need to provide to people who are going to be commissioning, to ensure that they are well equipped. It is a cause of sadness that, right throughout the UK, this skill has declined immeasurably over the past 20 years. They need to

understand, and I have been talking to the National Public Health Service about how it produces consistent needs assessments that can be compared and contrasted across communities. So, we retain a local focus, but when you come to look at commissioning with secondary care, you see that there is an amalgamation of all the skills within a community to get a better balance, and a very skilled set of contractors, which are part of those teams, to do the actual negotiation with the trusts. So, we have to do that.

[142] Included in that is what we are doing at the moment in terms of sanctions and incentives—and we have been discussing this for about a year—because I think that it is really quite an effective tool in changing behaviour, and incentivising those people who are doing a good job and who, of their own volition, will go further. We have commissioned an academic review of the effectiveness of sanctions and incentives, and we shall be providing advice to the Minister in the near future.

[143] In the meantime, we have set up a group to look at tariffs. Tariffs in England have been universally applied and there are some issues with that of which we are well aware; we have been in contact with my opposite number as tariffs have been implemented. We are looking at whether tariffs for elective care can be used as an incentive to those organisations that are running slick, efficient and timely services, to ensure that the tariff would include the aftercare required for a change in the process through which patients go. So, there is a lot of work going on with that, but the new framework for regional commissioning will come out within the next two months, and is due to start up in April. The vast majority of the south east of England has implemented its regional commissioning unit as an extension of the pilot that it has been doing for us.

[144] **Carl Sargeant:** Paragraphs 2.22 and 2.23 address the need to make day surgery the default position for elective surgery, and you have probably covered many of the possible answers with Alun Cairns. However, I recognise that the basket of procedures is a moveable feast; it is perhaps not accurate and up to date, and much work needs to be done there. However, if we have targets, we must work towards them. While some trusts have provided strong leadership for day cases and day surgery, other trusts have not provided the strong board-level support. What do you view as the key priorities to develop leadership for day surgery within the Assembly Government, among commissioning bodies and in trusts?

[145] **Ms Lloyd:** Paragraph 2.22(c) really hits the nail on the head. We must ensure that the accountability for delivering this rests with supported and supportive clinicians. In my experience, there is nothing like an enthusiastic clinician to make change that sticks and that is of huge benefit to patients. We must ensure that trusts are seeking out and encouraging those who have the support of their colleagues, are able to lead and implement a change in practice for patients, and have the confidence of their general practitioner community, colleagues and the whole of the clinical team to ensure that the changes are made sensitively, bearing in mind local circumstances. In my experience, that is what makes the difference. I know that the auditor general has suggested a board-level post, but I do not think that that is as powerful as the people who actually deliver the care taking the ownership and leadership for how this might be implemented. With my new Chief Medical Officer for Wales, we are tracking this very carefully. We are committed to clinicians on the ground taking that leadership, and being given the tools and the authority to do so. That is where the crunch points are.

[146] **Carl Sargeant:** I expect that Mrs Williams will probably agree with that point. Would you like to add anything that your trust has done, or what lessons have been learned in your trust?

[147] **Ms Williams:** The only thing that I would add is that day surgery should not just be a default position for clinicians and managers; there is nothing quite as powerful as it being the

default position for patients as well. We have to go through a process of educating patients at a national level to understand that day surgery is good, and is better for them in many instances than in-patient stays. There is nothing quite like patients sitting in front of a clinician asking, 'Why can I not be a day case?', to change the mindset. So, it is also about how we engage patients and the public more generally in making this huge cultural shift.

2.50 p.m.

[148] **Leighton Andrews:** Mrs Lloyd, it is all very well talking about engaging consultants, but the figures show that 21 per cent of consultant surgeons got no feedback on day surgery cases in their annual performance appraisals, and 19 per cent seemed to get no information at all on their day surgery rates. Some 48 per cent of anaesthetists did not receive support in respect of day surgery rates through their appraisals either. So, the performance appraisal system is not delivering.

[149] **Ms Lloyd:** That is why we have changed it. This has been the first year of the new CHKS assessment tool, which we have been using with clinicians. It was developed by clinicians, and the medical director of North West Wales NHS Trust particularly took a prominent part in establishing this database and the methodologies that would be used, which would reflect what modern practice per clinical specialty would look like when you looked at a consultant's job plan. It is disappointing that so few clinicians bothered to reply, but they were probably all a bit busy. Nevertheless, the hole that this reveals in terms of 'And how many people have ever talked to you about X?' is being filled by the new consultant appraisal process.

[150] **Leighton Andrews:** When will you get feedback on that?

[151] **Ms Lloyd:** We will get initial feedback in the middle of this year, but we expect it to be fully implemented by 2008.

[152] **Leighton Andrews:** On this, Mrs Williams, you laid great emphasis in your answer to Mr Sargeant on patients being part of the solution. However, the reality is that most patients tend to defer to their doctors, for reasons of professional expertise, respect, and so on. So, how are you, in your trust, seeking to engage clinicians specifically in this process?

[153] **Ms Williams:** It is about that clinical/managerial partnership, and about working with them throughout the totality of their practice. I referred earlier, in an answer to Mr Cairns, I believe, to surgeons wanting to operate and wanting to be able to do the work that they are employed to do. The biggest frustration for a surgeon is not being able to get an in-patient into hospital. If you incentivise the day-case process and get it working effectively, it also has significant knock-on benefits for in-patient care. We have to stop day-case surgery being the cinderella service that it was 10 years ago, and raise its profile and importance in the overall delivery of healthcare. Much of the investment that has so generously been made by the Welsh Assembly Government in day surgery facilities, equipment and staff over the past few years is beginning to make that shift.

[154] At the end of the day, we must have this robust performance management system. For example, in my organisation, we report on the day-case rates every month through our business processes on an exception basis. If patients are coming through the system who should have been day cases and were not, we flag them up, and managers go back to have conversations with consultants about why that happened. Sometimes, there are good clinical reasons—and people must be given the clinical freedom to make the right choices for their patients—but if they are managerial or operational reasons, such as, 'I was protecting the bed', or, 'I was ensuring that I was addressing some other social need', which could have been managed differently, that is flagged up and we can mitigate against it. However, it

requires constant effort.

[155] **Leighton Andrews:** All that made sense to me, Mrs Lloyd, but do you think that that is happening elsewhere?

[156] **Ms Lloyd:** Yes, it is obviously happening elsewhere, because of the rates in some of the organisations. However, it is not happening universally, which is where we must make the changes and the difference.

[157] **Leighton Andrews:** There is an obvious link in there between day-care performance and the freeing of resources to do other things in the NHS, is there not? You have presumably documented that, you know what it is, and you are able to remind trusts and LHBs about that.

[158] **Ms Lloyd:** Yes, quite. That is why we must strengthen the ability of the provider and the commissioner to have that discussion about how the resource will be used to the best value for the patients.

[159] **Janet Davies:** Paragraphs 2.31 to 2.54 are concerned with good practice in developing processes. Could I ask you, Mrs Lloyd, about the pre-operative assessments? They are an important aspect of the care pathway, but good practice is not always followed. What is being done to improve the extent and quality of pre-operative assessment?

[160] **Ms Lloyd:** The importance of pre-operative assessment was, again, emphasised in the NLIAH guide in September 2005. As part of the 2009 waiting times project, part of the return and discussion that goes on between us and the individual organisations encompasses pre-operative assessment. I think that even those organisations that did not indulge in pre-operative assessment a year ago are now starting to change. For example, in Gwent, a five-day ward has just opened that deals with elective surgical care. In the middle of that is the newly established pre-operative assessment unit, which means that patients are well screened before they get anywhere near the surgeon. They could be at the unit for a discussion about when they can come into hospital and how fit they are, and it means that they are visiting the ward that they will find themselves on when they come into hospital.

[161] It is very rare now for there to be no pre-operative assessment. Very good guidance has been published about it and the nursing teams that usually undertake the assessments have been well trained. They are usually nurse specialists and it seems, from the preliminary results that we have had back, that the patients find it highly satisfactory. They feel slightly less pressured, because they are not going to have their surgery immediately so they can get used to the idea, and they have a bit more latitude and time to ask what they want to know about how they will be cared for, whether as an in-patient or as a day case.

[162] **Janet Davies:** Mrs Williams, are you satisfied that pre-operative assessment processes are working effectively at your trust?

[163] **Ms Williams:** Yes, indeed. One of the critical factors associated with effective pre-operative assessment is trust among the clinical teams, because nurses working to effective protocols, screening patients appropriately and assessing both their clinical and their social needs to make the whole day-case process effective is probably one of the most significant factors in improving day-case rates. There was a lot of debate 10 years ago about the need for every patient to have a consultant anaesthetic assessment, which was hugely time consuming and very costly. However, now, with effective protocols, nurses are undertaking anaesthetic assessments within parameters, outside of which patients are referred for a secondary anaesthetic assessment. If that can be done effectively at the same time, on a one-stop-shop basis for patients, as it is in my organisation, it has huge benefits. Patients are then fully prepared as they arrive on their day of surgery and that is a positive experience for them.

[164] **Jocelyn Davies:** May I just ask, Ms Williams, how long before the operation does that assessment take place? Is there a set time for the assessment and, if patients have not had an operation within that period, will they have to have another assessment?

[165] **Ms Williams:** Yes. We try to time it for about six weeks so that, if the patient requires a secondary medical opinion, that can be sought and the patient's scheduled date is not affected. One of the things that we have been looking at most recently is having a follow-up telephone pre-assessment two days before admission to make sure that nothing has changed in the intervening period. At the moment, the onus is on the patient to inform us if anything has changed, and we monitor cancellations on the day of surgery because, sometimes, that has changed in the intervening six weeks. So, we are now looking at bringing in something two days before hand to mitigate against that as well.

[166] **Jocelyn Davies:** You could then offer that slot to another patient, could you?

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

[168] **Jocelyn Davies:** May I just ask you one or two questions about protecting beds? Sometimes, we find that patients are admitted the day before surgery, which is what Denise Idris Jones's mother got used to. She was used to coming in the day before, having the procedure and then staying the next day. Patients can feel very comfortable with that if they have experienced that several times because they see the sense of it. However, sometimes the surgeon does that to protect the bed. The report makes that quite clear. The majority of trusts, Mrs Lloyd, recognise that that is a problem, so what can we do to reduce that?

3.00 p.m.

[169] **Ms Lloyd:** One thing is to have dedicated day-case facilities. If you know that your bed or space will be there, you will have no need of protection. It is true that consultants will bring people in early to protect beds. I feel that we should have an informed discussion with patients about what their wishes and needs are, because patients generally do not particularly like being in hospital. Therefore, if there is an alternative, which will allow the consultant not to admit patients the day before, unnecessarily, when they will just lie in bed worrying and probably not sleeping either during the evening, I think that that is what we go for. One of the foci of the 2009 project has been this: where are you deficient in day surgery facilities? Allison's trust did not have any. However, there were other things that could be done to help her to have as effective a day surgery service as possible. A lot of money is being spent at present on trying to protect day surgery, because it stops the nonsense—understandable though it is—of bringing patients in too early.

[170] **Jocelyn Davies:** I take your point that patients might not necessarily enjoy coming in the day before—although we know that there are exceptions—but they do like certainty.

[171] **Ms Lloyd:** Yes, they do. Exactly.

[172] **Jocelyn Davies:** If you have had your assessment and think that you are going to have an operation in around six weeks' time, it is a big thing for most people to be having any sort of procedure, and they do like certainty. They arrange time off work and all sorts of things. I can understand why people want the bed, and to be certain that that is when they will have their operation. One of my family members had to ring up on the night before to check whether the bed was there, ring up on the morning to check whether the bed was still there, and then get there within half an hour. Day-case work is fine and it was fantastic to be able to bring that person home on the same day but it would be nice to have that certainty. I think that patients would benefit from that.

[173] As you have a rural area, Ms Williams, there are probably other social issues that you have to take into consideration—transport problems and considerable social pressures, I suppose—so, how does your trust do this? Do you admit any patients on the day before?

[174] **Ms Williams:** For day cases, it would be extremely rare. One way of getting around it, with day-case surgery, is that you do not actually use beds. You do not need to use beds.

[175] **Jocelyn Davies:** So, you do not need to keep the beds.

[176] **Ms Williams:** No. At the new day surgery unit that has been opened in Aberystwyth, we have recliner chairs for patients. The pressure on beds, overnight, is usually almost inevitably for acute medical admissions. The day-case environment, if it is properly constructed, is not somewhere where you could care for those types of patients. So, that particular issue, having segregated facilities and appropriately designed day-case facilities to meet the needs of that patient group, rather than a converted ward with beds in it that, if you are under pressure at night, are very convenient to admit a patient into without having to really sort the clinical decision-making out, is very effective. So, it would be extremely rare in my organisation to admit patients the day before. Patients with social problems and those coming long distances will be scheduled appropriately on the day's list. The Aberystwyth patients will get their operations at 8.30 a.m. and the patient coming from Cardigan will be operated on at 12 p.m..

[177] **Jocelyn Davies:** Thank you.

[178] **Janet Davies:** Thank you very much. I now call a short break.

Gohiriwyd y cyfarfod rhwng 3.04 p.m. a 3.21 p.m.
The meeting adjourned between 3.04 p.m. and 3.21 p.m.

[179] **Janet Davies:** Welcome back. We now move on to part 2 of the report. Irene, you have something that you would like to ask, do you not?

[180] **Irene James:** Yes, thank you, Chair. Paragraphs 2.45 to 2.48 show that a high percentage of patients were satisfied with the procedures for their discharge from hospitals, but the discharge process measured by the acute hospital portfolio did not score as highly in Wales as it did in England. We heard earlier from Mrs Williams regarding the benefits of nurse-led discharge and I note that not all trusts have this process in place. What are you doing to encourage trusts to follow best practice in this area?

[181] **Ms Lloyd:** We issued a circular on nurse-led discharge back in 2005 to accompany the guide. As part of the local action plans in respect of the 2009 project, we will be testing whether or not they have all implemented nurse-based discharge for day surgery. At the moment we largely have nurse-based discharge for standard and not very complex processes right across day and in-patient services, but particularly for day-patient services. They are to be regarded as the norm, working within sensible protocols, as Mrs Williams has said. That will be tested as part of these local action plans that are coming back. However, I was a little confused about this bit because it seems from page 33 that discharge in Wales was really not too bad at all. So I could not quite reconcile the two issues, because we would, of course, want to be better than England.

[182] **Janet Davies:** Naturally. Jeremy, do you wish to make any comment or leave it for the moment?

[183] **Mr Colman:** I am not bursting to say anything at the moment, Chair. [*Laughter*.]

[184] **Ms Lloyd:** We shall discuss the issue.

[185] **Jocelyn Davies:** Thank you, Mrs Lloyd.

[186] **Janet Davies:** We continue with a further question from Jocelyn.

[187] **Jocelyn Davies:** The major cause of inefficient performance of day surgery units relates to the ability to use the theatre properly, and have full use of it for the things that you would need a theatre for. How can trusts improve on that?

[188] **Ms Lloyd:** I think that this is really powerful information that the auditor general has provided for us, and it fits well with the work that the former innovations in care team has been undertaking as part of its assessments into day surgery processes, given the guide over the past year. With it, we will be taking this up with the organisations concerned because this is a matter of deep frustration not only for the surgeons, who do not like to be stopped and started all the way through their list, but also for us and for patients. If we can use the scheduled hours effectively—and it is very much about how you run a process well—then we can get more patients through and not affect the outcomes for patients either. I found it of real interest to see the auditor general's analysis of how we are using the staff and his assertion that we could increase day surgery without having to increase the staff. So this evidence, in particular, will be used as part of the assessment process for the local action plans to ensure that we are using those skilled staff well and not causing and building in frustrations, as is shown in figure 19.

[189] **Jocelyn Davies:** Thank you, Ms Lloyd. Ms Williams, what action has your trust taken to improve theatre utilisation?

[190] **Ms Williams:** One of the key issues within this is looking at what types of staff are doing what in the whole process. We have to use the levers that we have within the new contracts of employment, the consultant contract and the 'Agenda for Change' contracts, to develop new roles for staff, because one of the limiting factors is often the anaesthetist recovering the patient before he can then go back and anaesthetise the next patient and get the patient on the table. That downtime is time when a surgeon is not operating. There are various different ways of tackling this. In large operating suites, you can have floating anaesthetic staff—and I implemented this when I was working in the University Hospital of Wales a few years ago—who work between theatres so that you can provide the continuity of care, but have some additional resilience in the system so that you can decrease the turnaround time between cases. In smaller units that is inefficient. You have to look at developing new roles for operating department practitioners and for surgeons' assistants—we have trained one nurse as a surgeon's assistant in Ceredigion—and to look at these people getting the next patient into the anaesthetic room, working with the anaesthetic team to get that patient anaesthetised so that the handover process is much more seamless. So, it is a matter of horses for courses in terms of solutions. Some solutions require additional staff, but working with the new contract of employment and being innovative will provide other, different solutions for us.

[191] **Ms Lloyd:** As part of the 2009 project, we have recruited what we call 'early adopters'—three trusts that are working with us to consider the blockages to the provision of such seamless care. The evidence coming from them is being shared throughout Wales as best practice. Bro Morgannwg, North East Wales and Conway and Denbighshire are the three early adopters. We have given them some small extra resource to undertake this work with us, which is also a good idea.

[192] **Jocelyn Davies:** I have one last question: what is your assessment of the overall

quality of day surgery facilities across Wales?

[193] **Ms Lloyd:** That is variable. The capital programme has, as you know, been expanded, which is giving us the opportunity to improve these sorts of facilities. As you know, we have spent around £16 million of the capital programme on the Gwent and the Cardiff new units, which are coming along nicely. Certainly, the Gwent one is now fully commissioned and is doing very well. As part of the last waiting times initiative, we spent £30 million on improving day-care facilities in four units, one of which was Allison's, because she did not have any dedicated facilities. We have set aside £65 million as part of the 2009 project. We asked for bids from the organisations, which could cover diagnostics or day-case theatres or whatever. We had around 175 bids back, which have been whittled down to 48, because we have also increased the amount of discretionary money that trusts get from the capital programme. So, some of the schemes were so small that we said, 'Well, you have had an uplift to your discretionary money, so you can use it for whatever it was that you wanted'. We are also going through the 48 schemes with the organisations concerned to see where the maximum benefit will be gained. Most of them are relatively small schemes at around £2 million. One of them is much bigger; it is in Bro Morgannwg and is about £11 million.

3.30 p.m.

[194] So, it has to go through a different process. However, this is in an attempt to ensure that everyone has the opportunity to improve the surgical services and facilities that are necessary to deliver more effective patient care. They are certainly taking it up.

[195] **Janet Davies:** Irene, I know that you have the next question, but you also want to follow on from this point.

[196] **Irene James:** I want to ask about cancellations, because we hear a great deal about hospitals cancelling appointments, but we never hear much about patients who cancel. I notice, looking at paragraphs 2.74 to 2.76, that, in some areas, the numbers are up to nearly a quarter of all day-case surgery either not attended or cancelled by patients. How should we change that?

[197] **Ms Lloyd:** We have started breaking down the information on why patients cancel. If the hospital cancels, it will sometimes be because the facilities are not available or there will be problems similar to those that Allison talked about: there will be no bed, no theatre, sickness, illness or whatever. We have done a number of things about avoidable cancellations. In terms of clinicians, there is now a requirement that all clinicians advise us if they book leave within six weeks. It stands to reason that if they are unavoidably absent, then it is, of course, unavoidable, but let us try to use our facilities to the best effect. There are also issues about why patients cancel. They might be ill. However, pre-assessment and ringing up before they are supposed to come in should sort that out so that we can rebook.

[198] When the delivery support unit worked with Swansea, we had an issue on intervention with regard to how long before patients were told that they were having surgery. Many of us have worked with psychologists to determine the optimal time. During that research, we found that patients are unable to respond positively if they are told, 'You need an 'x' and you will come in in a week's time to have it done'. People must be given the time to acclimatise, to think of the questions that they need to ask, and to make the necessary arrangements. At one time, there was an issue in Swansea—and this might be reflected in the data—that it was on a treadmill and was giving appointments that were too soon. However, there are a number of reasons why patients might cancel. We have to get to the bottom of why that happens. Often, they will do it on the day, and we cannot use that slot if that happens. So, we must try to ensure that cancellations by patients and by hospitals are reduced to a

minimum. Jocelyn and I had a discussion at a previous meeting about cancelled operations, and we are doing far more work on the reasons behind these figures, because this is a waste and is a disappointment for patients as well as being disruptive to both patients and staff. If the patient cancels, staff could have been doing something else.

[199] **Irene James:** Thank you, I will move on to my next question. Paragraphs 3.1 to 3.3 and figure 22 refer to the modernisation assessment that NLIAH is carrying out at all trusts in Wales. What has the NLIAH modernisation assessment found to help trusts to improve their day surgery performance and processes?

[200] **Ms Lloyd:** It is comprehensive. I am prepared to share with you—I will not say where it is, though you can guess—what a modernisation assessment entails, because it is interesting.

[201] **Janet Davies:** Could you give us a note on that?

[202] **Ms Lloyd:** Yes, that is what I mean; I will send it to you. It is against the guide to good practice and the Department of Health's modernisation agency's 10 levers for change, which encompass all these issues. It looked at what the key levers for change were, and whether it was a question of facilities, staffing or process. The agency came out to state firmly in the guide that it was basically the process that was used, and if that was tweaked or managed differently, it would have a better outcome for both staff and patients. It is against those criteria and the whole of the guide to good practice that it has undertaken its modernisation assessment on day surgery. However, I will give you a completed copy of one.

[203] **Irene James:** Mrs Williams, has your trust found this work by NLIAH to be useful in improving day surgery performance and processes?

[204] **Ms Williams:** It has been incredibly useful on a few levels. One of those has been in confirming the areas where we felt that we were doing well; it is never a bad thing to have external confirmation of that. When you are performing well, there is a tendency, if you are not careful, to rest on your laurels a little bit. We found that the modernisation assessment has focused us on the parts of the pathway where we can do better. The other dimension is that, in the NHS in Wales, we are not good at sharing good practice. The value of the modernisation assessments, if they are to be truly valuable, is in how we share their outcomes between trusts, so that we can be clear on who is doing particular parts of the pathway well, and learn from that. From that point of view, it has been extremely helpful.

[205] **Irene James:** It sounds to me as though it has been extremely valuable, even if, as you said earlier, it is only in telling you, 'Yes, you have done well'.

[206] **Ms Williams:** Indeed.

[207] **Irene James:** That is something that we all need, is it not?

[208] **Ms Williams:** Yes, it is very motivating for staff.

[209] **Ms Lloyd:** It has found that 75 per cent of the total potential to increase day cases is in five trusts, and that 80 per cent of the potential is in seven specialties. So, it is quite focused now.

[210] **Janet Davies:** Mick, I know that you have a particular issue that you want to take up.

[211] **Mick Bates:** Yes. Earlier, Ms Lloyd, you mentioned that you wanted to encourage and strengthen the commissioning procedures. What impact do you think that that will have

on day surgery?

[212] **Ms Lloyd:** If you strengthen the ability of the commissioner to have an informed discussion with its provider, all best practice shows that day cases should be the norm. We work from that position. Therefore, we should be able to equip commissioners with the skills to have that discussion with senior clinicians and with the management of organisations and to work with them through the consequences of changing a pattern of care like that.

[213] **Mick Bates:** I link my next question to the concept of tariffs and the possibility of developing a fixed tariff. I would like you to put that in the context of cross-border commissioning, because the follow-up will be a specific question about the complexities of this. In terms of strengthening your commissioning, that is fine, but how do you perceive the operation in cross-border commissioning and the development of fixed tariffs in England?

[214] **Ms Lloyd:** The development of fixed tariffs in England, as you are well aware, has caused us no end of problems, because they do not just cover elective care. They cover the whole spectrum of care. It seems to me that, where an organisation is very efficient, and its costs are possibly 88 per cent of the tariff, then it will keep the rest of the resource. I, as a commissioner, would want to know what added value my patients were getting from that extra resource that an organisation had retained, and whether it was being used to best effect for the health needs of my population. That would be the sort of discussion that I would need to have.

[215] However, it is difficult, because although we have a number of patients from Wales going to England, it is quite a small proportion as far as they are concerned. We are still continuing a dialogue with Sir Ian Carruthers—I will see him again in the next couple of weeks about this—about these cross-border issues. The Department of Health was due to provide any additional resource to the commissioners where it found itself in this dichotomy where you have a problem of what else were you getting for your whole money when it could survive on 88 per cent of it? We are having a discussion, and John, particularly, has worked very hard with the Department of Health on this to see how we can have a redress in Wales. If we have tariffs in Wales, what are we going to gain from them?

3.40 p.m.

[216] The Minister still has to make his mind up about this. He wants, quite properly, to see the advantages and disadvantages of this and how we could use tariffs to incentivise best practice. That is the crux of it; we have to get quality if we put tariffs in. It is not just to be a financial transaction. How can the use of a tariff incentivise really good practice in services and improve the quality of the outcome for patients? That is the only reason that you would start to use tariffs. Unless it fundamentally affects that, why do it? We are having ongoing discussions with colleagues in England about this, because it has caused us no end of concern, as you know, particularly in Powys, where there has been arbitration, and we are just about to go into yet another arbitration about this. If organisations have been acquiring their services too cheaply, then there needs to be a mature discussion about that. However, my view would be, what added value are we requiring from our resources? I have to account for those.

[217] **Mr Hill-Tout:** Just to supplement that, whether it is cross-border or not, the auditor general points out how a tariff can be used by the commissioner. If the price of a general surgery in-patient is £3,000 and the price of a general surgery day case is £1,000 in the tariff, if you are a commissioner, whether you are asking for care from England or Wales, you would want to be saying to the organisation, ‘Well, why should I be paying when good practice and the targets say that this amount of work should be done as a day case? I should only be paying that rate’. Then you can have the debate, as Mrs Lloyd says, about how we use that money to improve the service. There is scope, almost, to reward. If you are a

commissioner and the trust manages to achieve the day-case targets, thereby reducing your costs, you can talk about how that money is used to reward and incentivise. So, I think that there is a place for elective tariffs, whether it is cross-border or not. However, as Mrs Lloyd said, the cross-border issues are compounding the complexity for us, in a sense.

[218] **Mick Bates:** There are two issues there. I listened very carefully to what you had to say about the whole issue of tariffs and the fact that you can incentivise the whole process through the money saved in it. Do you have any figures to suggest that there would be a significant saving from tariffs, which could then be used to incentivise other processes—more day surgery, for example?

[219] **Mr Hill-Tout:** We do not have any figures in an exact sense but we do know, from price tariffs at current costs, that a range of trusts in England and Wales are above tariff and a range are below. The objective is to bring them all to tariff, so we need to calculate the benefit—but also the disbenefits—of ensuring that we can reduce those costs. We do not have any exact figures, but we know from experience in England that it works.

[220] **Mick Bates:** Specifically on the cross-border issue—this is even more significant in Powys where there is no district general hospital at all, so you are dealing with many trusts in England—you said that it is a complex issue and that you are talking to people. Does that mean that you are getting to a point where there will be common practice down the borders so that providers like Powys Local Health Board can even improve on its day surgery position, which is pretty good at the moment? It appears to me that we are coming to a dead end, because the differentials that are emerging between the English trusts and our commissioning skills mean that we can no longer deal with trusts in England. It is becoming extremely difficult, as you know from the last arbitration.

[221] **Mr Hill-Tout:** My judgment would be, I think, that certainly the situation is difficult because a trust in England will be treating an amount of patients and the number of patients coming from Wales will be relatively small, as Mrs Lloyd said, in total quantity. I know that it varies according to size, but if they are dealing with several different commissioners, they are going to want to ensure that they can enforce tariff rates appropriately from their perspective. If Powys LHB is just one of those commissioners, it either has to go along with that or it gets into a dispute position, and, as you know, we have had disputes. That is the current situation.

[222] You are asking whether we might be able to smooth that position by having general agreement with the Department of Health in London almost to neutralise the impact of that on the Welsh commissioners, because this is an English system. We are working on that at the moment, as Mrs Lloyd said, and we are having discussions. The jury is out on whether we will be able to smooth that. In the interim, we have agreed a process of dispute conciliation and agreements. As you know, we have had one or two of these problems, which had to be arbitrated by senior people from England and Wales to reach a satisfactory decision; that has happened on two occasions so far. So, we have that interim solution, but it is too early to say whether we can smooth the position permanently.

[223] **Ms Lloyd:** Also, we have to make a decision as to what the alternative is. In some parts, to which Powys looks for care, at the moment, there could be alternatives. I have advised that chief executive to consider carefully the alternatives that are available to him if he wished to bring patients back to Wales, and where they could go—in consultation with the patient groups, of course. Is there a viable alternative?

[224] **Mick Bates:** Thank you for the rhetorical question.

[225] **Jocelyn Davies:** We ask the questions, Mrs Lloyd; do not ask questions of us.

[*Laughter*.]

[226] **Mick Bates:** That is an interesting discussion. Finally, Allison, I am sure that you listened with interest to that, from Ceredigion's point of view. What potential do you see—if it is possible to give me an indication in terms of a proportional figure—to increase day surgery, and thereby reduce the overall waiting time, as a general figure?

[227] **Ms Williams:** I think that there is huge potential. What we are seeing as the waiting times have come down lower and lower across the board is that patients are being operated on sooner and that their general health, when they are being operated on, is better. So, over time, you would imagine that more patients will become suitable for day surgery as the waiting times come down; there is a knock-on effect. Day surgery has a major role to play in terms of the overall waiting list position, not just in the provision of day surgery itself, but in freeing up those very costly and labour-intensive resources within in-patient facilities for the types of patients who require that kind of surgery. We have a mindset shift, because we are moving to procedures that are now categorised as out-patient procedures, day-case procedures, five-day procedures, or short-stay procedures, and traditional in-patient procedures. It is only when we have the ducks in a row, with the right patients being streamed according to their need, and the right way of delivering their care that we will really drive the waiting times down. I believe that we are on the cusp of that, and day surgery is just the start of that push, which will, overall, achieve a reduction in waiting times in Wales.

[228] **Mick Bates:** Thank you. I will leave it at that.

[229] **Leighton Andrews:** Mrs Lloyd, if you do not get day surgery right, you will not hit the 'Designed for Life' targets for elective surgery, will you?

[230] **Ms Lloyd:** No.

[231] **Leighton Andrews:** So, how much of the £80 million that you have from the delivery support unit money will you be devoting to day surgery?

[232] **Ms Lloyd:** A lot. [*Laughter*.]

[233] **Mr Hill-Tout:** I cannot give you the exact figure. The £80 million allocated to achieve the 2009 target is going out to the NHS on the basis of the local delivery plans that they have to submit. They submitted theirs for this year, and the second phase of those plans is currently due in this autumn. We have a group of adjudicators who will be looking to see whether those plans are offering us the main aspects that we require. So, day surgery is absolutely crucial. We will be looking for increased day surgery rates in accordance with our efficiency targets, and we will be looking for evidence of modernisation and efficiency and evidence that referral management centres are managing the demand that we talked about two to three months ago in the waiting lists report. We will be looking for all of those things. Effectively, the plans will be rejected unless they satisfy the criteria, and day surgery will be a major part of that. I do not know what the distribution of the revenue will be, but I can find that out once we have completed the plans and let you know.

[234] In terms of the capital, in addition to that £80 million, Mrs Lloyd has already referred to the fact that we have, from the capital fund, an allocation of £65 million, which we have told the NHS to use to support the 2009 target. So, it is coming back with plans to increase day surgery, and plans for better diagnostics, better x-ray equipment and improved operating theatre equipment. So, again, through that route, we should also be saying to the NHS that day surgery is an absolute must.

3.50 p.m.

[235] **Janet Davies:** Ms Lloyd, you have indicated that you are already using this report to improve your performance. Are you satisfied that the Assembly Government has the right measures in place to take full advantage of the opportunities that exists to raise the day surgery performance?

[236] **Ms Lloyd:** Yes, I am. I think that the measures have been carefully developed over the years. This is valuable information to add to it. The modernisation audits have been fundamental to our gaining a more comprehensive understanding of where all the organisations are. In one way, it was heartening to know that we are not dealing with universal poor performance. There are people who have improved their delivery of services enormously and can show the way to others, but there are focused areas on which we need to concentrate. In their monthly performance monitoring of these organisations, the regional offices will pay particular attention to the plans and the action that they are taking to improve day surgical rates for their populations.

[237] **Janet Davies:** Thank you. Ms Williams, you talked about everything being on the cusp of lining up. Do you feel that you have the right measures to do that?

[238] **Ms Williams:** I think that we have. The performance management and the performance monitoring measurements are in place and will develop over the next two years. The culture is shifting, but culture takes time to shift, and it is public culture as well as clinical culture, but we are seeing shifts in that. The more we can do with primary care and managing patient expectations and engaging them in the processes of defining their own care, the better. As we bring all of these together, provided that people like me take their accountabilities seriously and drive these performances up, I am confident that we will see the improvements that our patients deserve in Wales.

[239] **Janet Davies:** Thank you very much. I am sure that everyone looks forward to seeing the developments and the progress. To finish, I thank Ms Lloyd, Ms Williams and Mr Hill-Tout for their helpful and informative answers. You will receive a copy of the transcript to check for any inaccuracies.

3.53 p.m.

Gweinyddu Grantiau Cynnal Addysg a Hyfforddiant (GCAH) a'r Gronfa Ysgolion Gwell
Administration of Grants for Education Support and Training (GEST) and the Better Schools Fund

[240] **Janet Davies:** We have two sets of responses from the Assembly Government to consider. Jeremy, can I bring you in first on the administration of grants for education, support and training and the better schools funding? Do you have any comments to make?

[241] **Mr Colman:** In my opinion, this response is entirely satisfactory. I make a slight reservation in my letter to you about the Welsh Assembly Government's approach to three-year budgets—there is scope for uncertainty as to whether it really is committed to three-year budgets. The response talks about moving towards three-year budgets while retaining in-year flexibility. For that reason, we will look closely at what it does, but I think that it is an acceptable response.

[242] **Janet Davies:** Thank you. Do Members have any comments? I see not.

3.54 p.m.

Gwasanaethau Iechyd Meddwl i Oedolion yng Nghymru: Adolygiad Sylfaenol o'r Gwasanaethau a Ddarperir
Adult Mental Health Services in Wales: A Baseline Review of Service Provision

[243] **Janet Davies:** In terms of this item, I feel very concerned—not about the Assembly Government's response, but about the whole service. I do not think that it is good enough.

[244] **Mr Colman:** As to the response, the Welsh Assembly Government has taken all the recommendations that this committee made very seriously, and it has accepted them without reservation. As regards recommendations, you cannot hope for better than that. Our work, and the committee's inquiry, at its hearing, showed that you are right—there is considerable scope for improvement here. It is highly likely that we will wish to return to this subject. Therefore, it is a satisfactory response, but the situation requires careful monitoring.

[245] **Janet Davies:** The committee will keep an eye on it. Does anyone wish to make any comments on this? I see that you do not.

3.55 p.m.

Cofnodion y Cyfarfod Diwethaf
Minutes of the Previous Meeting

[246] **Janet Davies:** Are you all happy with the minutes of the previous meeting?

[247] **Carl Sargeant:** My apologies were sent in, which is recorded. However, I was not here because I was at another committee meeting in north Wales. It is difficult—you cannot be in two places at once. Therefore, it would be helpful if that were noted.

[248] **Jocelyn Davies:** This committee should not clash with anything, should it?

[249] **Carl Sargeant:** It was an external committee meeting.

Cadarnhawyd cofnodion y cyfarfod blaenorol.
The minutes of the previous meeting were ratified.

3.56 p.m.

Cynnig Trefniadol
Procedural Motion

[250] **Janet Davies:** I call on someone to propose that we end the public part of the meeting.

[251] **Leighton Andrews:** I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 8.24(vi).

[252] **Janet Davies:** I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 3.56 p.m.
The public part of the meeting ended at 3.56 p.m.