Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 18 Hydref 2007
Thursday, 18 October 2007

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Eleanor Burnham	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Chris Franks	Plaid Cymru The Party of Wales
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Helen Mary Jones	Plaid Cymru The Party of Wales
David Melding	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

John Baker	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru, Swyddfa Archwilio Cymru Auditor General for Wales, Wales Audit Office
Gill Lewis	Swyddfa Archwilio Cymru Wales Audit Office
Ann Lloyd	Pennaeth, Adran Iechyd a Gofal Cymdeithasol Head, Department for Health and Social Services
John Sweeney	Cyfarwyddwr y Gyfarwyddiaeth Polisi Iechyd Cymunedol, Gofal Sylfaenol a Gwasanaethau Iechyd Director of Community, Primary Care and Health Service Policy Directorate
Mandy Townsend	Swyddfa Archwilio Cymru Wales Audit Office

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

Dan Collier	Dirprwy Glerc Deputy Clerk
Dr Kathryn Jenkins	Clerc 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] **David Melding:** Good afternoon; I welcome you all to this meeting of the Audit Committee. I welcome committee members and officials, who I will introduce a little later, and also members of the Wales Audit Office.

[2] The committee proceedings will be conducted in English and Welsh; when Welsh is spoken, a translation will be available on channel 1 of your headsets, and channel 0 will amplify our proceedings for anyone who is hard of hearing. I make the usual request for you to switch off all electronic devices completely, so that they do not interfere with the recording system.

In the case of an emergency, please follow the instructions of the ushers, who will help us to leave the building safely. I have received no formal notification of apology for absence. I now invite Members who need to declare an interest to do so. I see that there are no declarations.

1.32 p.m.

Adolygiad o'r Contract Gwasanaethau Meddygol Cyffredinol Newydd yng Nghymru
Review of the New General Medical Services Contract in Wales

[3] **David Melding:** I welcome Ann Lloyd and John Sweeney, who are here as the accountable officers. For the record, the auditor general's important report shows that the new general medical services contract is helping to improve primary care services in Wales and is integrating general practitioner services more effectively. However, changes are needed to the way that the contract is run. The report identifies a need to monitor more closely the money given out to GP practices. It is vital that we seek to find out what needs to be improved and why, and also to focus strongly on the future, so that this session and our subsequent report support the improvement of primary care services. That sets the context and, again, I welcome Ann Lloyd and John Sweeney, who will be familiar with the way that the committee works.

[4] It falls on me to ask the first question, to which there may or may not be supplementary questions, and then we have allocated questions that other Members will pose in turn to cover comprehensively the reports' findings. Given how complex the negotiations were, and the many other changes that were occurring to the way that health services were delivered, do you think that the new contract has represented a good deal?

[5] **Ms Lloyd:** The benefits arising from the new contract are becoming clearer by the day. You will recall—it is outlined in the auditor general's report—that there was considerable concern that general practice services would collapse; there was great disenchantment out there and we were living with a contract, through the red book, that would not serve the needs of the strategies and the people for much longer. It is of great credit to everyone who negotiated that contract, the local health boards that had to implement it and their GP colleagues, that, between the vote taken by the British Medical Association on this and the implementation of the contract, there were only nine months to get the legislation through and everything set up. People worked assiduously together to do that.

[6] When you look at what has happened with the contract over the first few years, there is clear evidence already, as outlined in this report, of some of the benefits coming through. We have aimed to improve equality and access to services for people, and that is coming through clearly. We aimed to have an out-of-hours service that was based on principles and a

service specification, and that is being done—we are about to put the out-of-hours services out to tender again.

[7] There is a definite and maturing relationship now between the local health boards and their GP practices. We are seeing GPs taking the opportunity of extending the breadth and the depth of their services. We must concentrate now on really maximising the contract's potential so that we overtly develop high-quality services there, because we are going to need this contract, and whatever flows from it. There will be ongoing discussions with the General Practitioners' Committeee nationally and between the four nations to look at how it can really allow us to achieve 'Designed for Life', our community services strategy and, in particular, the rural healthcare plan, to which the Minister referred, which will be coming through in the next year. It is not perfect yet, but it has potential.

[8] **David Melding:** If you were having to negotiate the contract again, or if you were in a process in which this was a new initiative, is there anything that you would do fundamentally different? We will obviously drill down to various details, so there is no need to be exhaustive. How did it work in terms of the UK having four devolved departments working, and that sort of focus?

[9] **Ms Lloyd:** Mr Sweeney was more intimately involved in its negotiation than I was, so I would like him to answer your second question. However, as to what we would have done differently, I think that one must remember the enormous sensitivity and care with which this particular contract had to be negotiated. There was a very distinct possibility that GPs would just walk away and become private practitioners—a sort of GP model of Denplan or something like that. That was a serious concern, because there had been a ballot of general practitioners just a short time before in which some 86 per cent said that they were prepared to walk. Whether they would have walked if it came to the crunch is a matter of speculation, but it really was a serious concern, and I do not think that it was shroud waving, either. So, we were in a difficult position in trying to achieve what the employers wanted, namely a contract that provided us with much more flexibility, which allowed local health boards—primary care trusts in England—to negotiate directly with GPs and to put the emphasis not on quantity but on the quality of the service being delivered, and which guaranteed an income for general practitioners that would be attractive and would allow us to continue to be able to employ people.

[10] We also needed a contract by which we were not just employing GPs, but giving money to a whole practice, which should encourage them to employ a greater range of staff to improve access for patients who did not particularly need to see a GP but who nevertheless needed interventions or continuing care. That will be essential when we get to the implementation of the Welsh chronic disease management framework.

[11] Although there are features of the contract that would not necessarily cause managers to throw their hats in the air with joy, nevertheless, it has given us those important planks on which we can build for the future. We do have sensible negotiations with GPC Wales about how we can use the competence within this contract to deliver more services to people in a more appropriate way.

[12] **David Melding:** We will obviously drill down to some of the detail. John Sweeney, do you want to add anything about how the negotiations among the devolved nations and Governments progressed?

[13] **Mr Sweeney:** Yes, Chair; thank you. If I may, I will just spend a sentence on the first part of the question. With the benefit of hindsight, we may have dug our heels in a little more on the minimum practice income guarantee. At the time, however, that was a concession that was agreed UK-wide in a bid to get a very difficult contract through and agreed by the GP

community in the atmosphere that Mrs Lloyd has just described.

1.40 p.m.

[14] As far as the relationship between the four departments was concerned, the truth is that we held on to it by the skin of our teeth. Devolution was new at the time, and you will know from your chairmanship of a previous committee that that committee expressed reasonable scepticism about or ability to meet various targets, such as out-of-hours targets, and to get the money for the contract in the first place. The only way that I can describe the atmosphere around the negotiations is that it was like the time when a major Bill affecting Wales goes through Whitehall—a huge juggernaut is set in motion. We have a small team, so we were scrambling to get the legislation together, to issue guidance to LHBs and to do all the other things that were required to get the contract in place in a very short timescale.

[15] At the same time, we were negotiating separately with our General Practitioners Committee in Wales about what its concerns were and trying to reach agreement as to how we would present those in UK negotiations. So, it was a pretty frenetic atmosphere. We relied on the huge numbers of Department of Health civil servants who could do all the ground-breaking work such as health economy assessments and formula calculations, and so on, and we did our best to check those for the Welsh context. It would be wrong to pretend to the committee that we were dealing with it in a measured way, but we hope that we managed to get our views across. With the help of our LHB colleagues, we at least put the mechanics into place in time.

[16] **Ms Lloyd:** It was negotiated by NHS employers, which was the confederation. So, there was an extra interface with which we had to connect.

[17] **David Melding:** We have got off to a very helpful and candid start, and I am sure that this will continue.

[18] **Lorraine Barrett:** I am looking at point 1.4 to point 1.18 on page 16 of the auditor's report, under the heading which includes the words 'significant benefits to GPs'. These benefits include 25 per cent more income, no Saturday morning surgeries or obligation to provide out-of-hours cover and the ability to choose which extra services they provide. Do you feel that the benefits to the GPs are balanced by the benefits to the NHS and to patients?

[19] **Ms Lloyd:** It all depends on what GPs now think of their contract. In terms of what indicators we can use to assess that, recruitment is going extremely well and hardly any vacancies are now seen in Wales, as many people are applying to be GPs. For the first time, we are oversubscribed for registrar training and for people expressing an interest in general practice training throughout Wales. So, there must be something about this contract that is attracting people. At the same time, we are also attracting far more young doctors who want to be salaried GPs, so the platform of general practice is improving not just for independent contractors, but for others.

[20] On the question of whether or not it has benefited us, the quality indicators are improving year on year. We had the 2006-07 outcome yesterday, which shows again that the quality is continuing to improve as the ways in which they can earn those points get much harder. So, we are getting a proper evaluation of the outcome benefits of this contract. It is a bit soon to do that and we have to let it run for another couple of years, but we are starting to track those improvements as they run through the system.

[21] It would have been a disaster to have no general practice service in Wales. We would not be able to provide the range of care that is necessary, and we would certainly not be able to promote the strategies that are so important to us. We will have to wait and see, by doing a

proper external evaluation, whether or not the costs and the benefits are balanced.

[22] **Lorraine Barrett:** I was going to ask you about your expectations for the long-term impacts, but you started to cover that point by saying that quality is improving and that you expect it to continue. Do you think that value for money will improve as time goes on?

[23] **Ms Lloyd:** The problem with value for money is that we have the minimum practice income guarantee, and it would have been ideal, from our point of view, to have the Carr-Hill formula, which looks at the funding of deprived communities in a more appropriate way than others. There is then the quality framework on top of that, and the whole issue of funding surveys to find out what patients think of the care, the service and the access that they are getting.

[24] We are not unlike the rest of the UK, as you have seen from this report, and 90 per cent are on the minimum practice income guarantee. MPIG should be eroded as the core increases. So, it is quite difficult to be absolutely definitive about value for money. We can only go on whether the core funding under the Carr-Hill formula is starting to work, although that has been frozen because there has been no uplift in the past two years. Are we getting value for money for that which we can measure? We can also use the outcomes of the patient surveys to assess whether or not there is an improved recognition by patients of the care that they are getting.

[25] **Lorraine Barrett:** May I just—[*Interruption.*]

[26] **David Melding:** We will return to some of these issues later, so I do not want to give too much away, but you obviously know what questions are to follow, Lorraine.

[27] **Lorraine Barrett:** I just have one small point. Point 1.9 refers to out-of-hours services and the 24-hour responsibility for all patients. How many GPs would have been on call for 24 hours, because, from my personal experience, we would only see a locum during the night? Is it because GPs will be paying for that out-of-hours service?

[28] **Ms Lloyd:** Yes, they would have been responsible.

[29] **Lorraine Barrett:** And that would have been their choice?

[30] **Ms Lloyd:** Yes.

[31] **David Melding:** Irene, some of your questions have already been covered, but do you want to explore any of them further?

[32] **Irene James:** We have hears that the contract has achieved many of the objectives, but how have vacancy rates improved as a result of the contract?

[33] **Ms Lloyd:** The number of vacancies was quite high in Wales—[*Interruption.*]

[34] **Irene James:** Especially, as you said, in deprived areas.

[35] **Mr Sweeney:** Vacancies in Wales have more or less disappeared, because, as you can see, there are no advertisements. However, we have always been concerned, because of the age profile of the GPs concerned, about the Valleys areas. To give you an indicator, there was a vacancy recently in Rhondda Cynon Taf, and there were 36 applicants for that post. So, without being complacent about it, general practice seems to be a very attractive option for doctors at the moment.

[36] We were facing a real problem with the retirement bulge, and we think that this contract has removed that threat, and, fortunately, it has removed the threat in some of the most difficult areas in Wales.

[37] **Irene James:** Has that removed the threat just for now or is it far-reaching?

[38] **Ms Lloyd:** There are a number of GP registrars also coming through, and we increased the number anyway under the Labour party's manifesto the previous time when we invested more. However, if you look at the three-month vacancy rate, for example, it was just over 3 per cent in 2003, and, by September 2006, which is the latest return that we have, it has gone down to under 1 per cent. That is important, but I do not think that we can be complacent, because we know that in the south-east, just over a quarter of GPs are over the age of 55 and are likely to retire over the next few years. That is why we have increased the number of GP registrars, so that they will come through. We are trying to ensure that there is an appropriate number of training places in the areas where there is the highest risk of many GPs retiring. However, the salaried scheme has been helpful; it started quite small, but has increased exponentially over the past three years. The scheme is drawing in young GPs to the Valleys, to the more deprived areas, where we know that there are GPs who are going to retire in the near future. So, we are almost planning ahead to ensure that there is no blip. There was a blip in north Wales, as you can see from the auditor general's report, but that is again reduced.

[39] **Irene James:** Do you think that that has a direct link to the contract?

1.50 p.m.

[40] **Ms Lloyd:** Certainly, more people are interested in coming into general practice as opposed to going into other fields. You will know that the number of consultant medical staff that we have employed over the past few years has also increased quite considerably. However, in terms of GP careers, they are still holding their own and are growing.

[41] **Helen Mary Jones:** First, I apologise for being late, Chair.

[42] We have heard about the number of salaried GPs coming into some of the more challenging areas. Do you see those salaried GPs staying in the salaried service or do you think that, given the level of incentive that is on offer in the private contract, we are likely to lose people out of the salaried scheme to more traditional GP practice?

[43] **Ms Lloyd:** From talking to those young salaried GPs, most of whom are women, it is clear that they do not want to run a business; they want to be a GP, which is the major selling point of a salaried service. They have expressed great satisfaction with the regime in which they work; they have good assessment, good supervision and a good team to whom they can refer. I do not think that any of them left the salaried service because this is the regime in which they want to work. They have been extolling the virtues of the scheme to their colleagues because more and more of their young colleagues, with whom they graduated, are coming into salaried schemes. We should promote that, where appropriate.

[44] **Mr Sweeney:** I would not pretend for a moment that this was an intended consequence of the contract negotiations, but what the contract has done, especially for women, but not only for women, is introduce all the modern organisational employment trends that we see in other areas, such as job sharing, part-time working, and so on. All of that is now possible for a new cohort—I think that that is the jargon—of GPs. As Ann said, they seem to find it an attractive option.

[45] **Eleanor Burnham:** Are you asserting that they are self-employed and running

businesses in the main?

[46] **Ms Lloyd:** General practitioners are independent contractors in the main.

[47] **Eleanor Burnham:** I have many issues with the assertion that patients can expect to see their GP promptly. We are obviously achieving quantifiable targets, but the NHS should be about caring, and I have an issue with my GP surgery, for example, which does not open until 9 a.m.. In terms of access, you might be able to say that quantitatively they are reaching their targets, but I am concerned about appropriate timing of appointments for people who work. There is a huge issue as to why many GP surgeries do not open until 9 a.m., and then you have to hang around, if you are lucky enough to get them on the phone at 8 a.m. to make an appointment. Is all of this based on quantitative targets rather than on quality of care? Why can we not achieve more client satisfaction, namely the patient, as much as satisfaction, hopefully, for the GP?

[48] **David Melding:** Yes, but they instantly achieved their access targets.

[49] **Eleanor Burnham:** Yes, but I think that there is a difference between the quantitative targets and what we, as patients, would like to see, namely a little bit of help. I will tell you this story briefly: when I last spoke to my GP, he said to me on the phone, 'It is your fault as a politician that you cannot get an appointment tomorrow'. That is anecdotal, but how can we improve that kind of attitude on behalf of my constituents?

[50] **David Melding:** Thank you for that cameo. They did all achieve their access targets practically overnight. Is that what you expected or did it reflect existing good practice, or has not much been done other than form-filling?

[51] **Ms Lloyd:** That is why we changed the access target, because it did seem to be easy. I share your frustration. The same thing happens throughout the UK. The access target needs to be very carefully interpreted, because being able to see someone in fewer than 24 hours relates only to emergencies, but you should be able to pre-book. However, universally in the patients' surveys, people say that they want more flexible access, and so, in the next round of UK negotiations, we in Wales will say that we want to see better access at reasonable times, on the weekend or one evening a week. That way, if you work, as most of us do these days, you will not have to take a day off to see your doctor, and if you are really poorly, you will have the assurance that you will get to see somebody appropriate the same day. That is part of taking this forward, is it not?

[52] **Mr Sweeney:** Yes, it is. I think that the criticism is very fair. We have all heard stories like that and we get complaints about it. We have squeezed a lot of the particularly stupid ideas out of the system, but we have not succeeded in losing them entirely. We have attacked the idea that you can book for only that day and not further ahead. That was a misunderstanding of the target. We still hear stories like that but, fortunately, instances of that particular one are diminishing. We really need to put a squeeze on LHBs and GPs to make access a reality, as we want it to be.

[53] In the unofficial, secret-shopper approaches that we have taken to this, we have found that the picture varies a great deal around Wales. There are remarkably good access practices in certain areas, and it probably varies in your own area. However, one bad story has far more currency and news value than all the good ones—although that is not for a minute to take away from the fact that we see the problems exactly as you have described them. We have to focus on them and try to make access a reality for all in Wales.

[54] **David Melding:** Were there any specific follow-ups that you wanted to ask, Eleanor? It was a fairly clear answer.

[55] **Eleanor Burnham:** It is really important that everybody can gain the proper, appropriate access, and not just when the GP feels like it but when people need it, so that they can pursue their own work.

[56] **David Melding:** Staying with access, Darren Millar has a point.

[57] **Darren Millar:** We all know why everybody managed to achieve the access targets overnight in the report: it was because of the self-declaration rather than there being a more rigorous system of auditing. While things have been tightened up, the report still indicates that the level of evidence required to support the fact that access is taking place within the timeframes is a bit patchy in different areas. Do you have a comment on that?

[58] **Ms Lloyd:** That is why we are tightening up the sorts of checks that the local health boards must undertake. One of the other great frustrations is that, when you ring up the surgery at 8 a.m., you are kept hanging on for ever and a day, and you do not like to put the phone down just in case it is your turn next. That is not appropriate. One element of the access target is that telephone answering services be fit for purpose. If you have to hang on, it is not fit for purpose.

[59] You have alluded to the Neath Port Talbot mystery-shopping audit, and we have done some of that here. We have brought the attention of other LHBs to that, because the access target is the one that makes a huge difference to how general practice is viewed by the community and, therefore, we have to get this as right as we can. So, a lot of attention is being paid to this target and how it might be altered or managed differently. We have to ensure that what we require at the moment is being achieved, which is why we are endorsing the experience of Neath Port Talbot with its mystery-shopping systems.

[60] **Darren Millar:** And there will be a level of consistency across Wales as a result of that, will there?

[61] **Ms Lloyd:** There should be a growing level of consistency, because either LHBs will meet it or they will not—or they might meet parts of it but not all of it. So, we will have a better picture after next year.

[62] **Darren Millar:** But in terms of the evidence, the rigour—

[63] **Ms Lloyd:** Yes.

[64] **David Melding:** That is very helpful. We will move on. Chris Franks has a question.

[65] **Chris Franks:** Most practices in Wales are now achieving the 700 points on QOF. Does this mean that they are achieving acceptable standards of patient care?

2.00 p.m.

[66] **Ms Lloyd:** QOF at 700 points is not the maximum; we would aim to get everyone up to 1,000 points. However, 700 is far better than it was two or three years ago, but we are striving to get everyone up to the maximum and to get consistency throughout Wales with regard to which elements of QOF they are meeting. There is quite a variety. Given the health needs of our population, the local health boards and we are paying particular attention to whether the real health needs are being addressed through that QOF system and the points being gained in that way. Most years, we will change the framework and consider what else we need to do, given the health needs of our population, to ensure that there is an improvement in quality through QOF. Those are the discussions that we have with the

General Practitioners' Committee (Wales) and with the UK partners.

[67] **Chris Franks:** LHBs figured in the previous question, quite rightly. Are you confident that the local health boards have adequate resources to do what you suggest they should be doing? Have we allocated additional resources for them to carry out their duties? Can you give us a flavour of whether all LHBs are properly resourced? What is the situation out there?

[68] **Ms Lloyd:** LHBs are small organisations, as you know, but improving primary care and access to it is one of their major responsibilities to their populations. They have learned from each other. We have sent out guidance and trained them to do it. They are learning from each other how best to undertake the checks to ensure that the QOF points are appropriate. Caerphilly Local Health Board is highlighted in the report, as it has done a magnificent job and takes its responsibilities very seriously indeed. The Caerphilly team is helping other teams to improve their management and regulation of the whole contract, particularly the QOF.

[69] Like any other management system, LHBs have to apply their resources to that which is most important. This is a fundamental contract, which makes a great difference to how care can be provided in communities and how health needs might be addressed. Through our guidance and training programmes, the boards know that we expect them to ensure that the not inconsiderable resources that have gone into this contract are applied effectively for the benefit of their populations. They take it seriously.

[70] **Mr Sweeney:** Most of the checking on QOF is done electronically, because the LHBs can interrogate each practice's software. That supplements any physical checks that need to be done. That is why that part of the contract was designated as being 'high trust'. A lot of the checking could be done immediately by the information technology systems. There was no need for groups of inspectors to go around to practices every month, disrupting the normal flow of clinical work.

[71] **David Melding:** We have time to touch on some of these qualitative issues and the rigour of the process. On related themes, Janice Gregory would like to ask the next question.

[72] **Janice Gregory:** Like Lorraine, I will indicate the part of the report that I am looking at: paragraphs 1.34 to 1.39. The report says that one specific and laudable objective of the new contract was that there would be a long-term benefit to patients in the form of improved health. The report mentions hypertension and diabetes. Have you any indication of when we are likely to see these long-term benefits coming through? It would be interesting to hear about any benefits, but I would like to hear about the chronic benefits. QOF is the quality and outcomes framework, of course, for anyone watching out there who would not know that. I do not know whether you can give us some idea on that, as well, Ann.

[73] **Ms Lloyd:** You need to look at how the QOF indicators are chosen for a start, and why. We know that effective chronic disease management is absolutely fundamental over the next 10 years, particularly in Wales, because we know that problems will increase significantly unless chronic disease management is effective and starts to move into community and primary care settings far more than it does at the present time. The negotiators, who include professional advisers, the general practitioners' committee and us, will look at which indicators are likely to show, or which interventions will effect, an improvement in the management of chronic diseases. That will mean that the problem is picked up earlier, that people get the intervention that they need earlier, and that their care is monitored longitudinally in a far more effective way. That is why we look extensively at the research and evidence that comes out. There is an academic group that looks at, and will advise us on, which indicators are likely to be able to show an improvement in care over the

medium and long term. That is underpinned by the national service frameworks that we have, and the National Institute for Health and Clinical Excellence and all the other advisory bodies.

[74] There is a very serious debate about which indicators should be included in QOF to give us the best indicator that care is improving. The disease areas that we have been looking at are of fundamental importance. The first way in which we measured QOF was by having a register of the people who suffer from these diseases; you cannot start to treat them properly unless you know where and who they are. So, LHBs got their first QOF points for at least collecting, for themselves, the people who fell into these areas. Now we have started to move through what care path we need general practitioners to adopt to treat the patients the best. There is a great deal of work going on in that area.

[75] The QOF expenditure has risen as we have collected more information and developed more care pathways for the chronic diseases that are giving us, and people out there, such a problem. On the chronic disease framework for Wales, there will be a further discussion with the experts, with the professionals, and with the General Practitioners' Committee (Wales) about how we can assure ourselves, collectively, that we have the most effective indicators, allowing us to track the improvement in the management of chronic diseases as we roll out the framework.

[76] One of the interesting things that we are about to embark on is a real-time model of what services look like at the moment and which services we will need to put in place in the next five to 10 years, given the very different way of managing people with a chronic disease. We will start by looking at two of the local service boards that have been piloted in Wales. So, you would have all your partners around the table, running a live model. All the partners will be there, including local government and housing, which is vital, and education and leisure, as well as health and social services. We will be able to interrogate the model with such questions as, 'Where are the resources at the moment?', 'Where should they be moving to?', 'Do you need double running costs?', and 'How is it going to come?'. The clinical indicators will arise from that, which we will then feed back into the QOF, to tweak it so that we can track how care is being developed and how it is improving in the community setting in Wales.

[77] With QOF being where it is at the moment, and with our new chronic disease management framework, which the Minister launched a little time ago, we have a very good vehicle for seeing how general practice in the round is contributing to a very different model of care. Of course, fundamental to that is what the patients want. Within these models, the expert patients have been very helpful in describing the style and system of care that they require, and the hurdles that they have had to overcome. Again, we can build that into the care model. I am sorry that that is a long answer, but it shows where the quality and outcomes framework sits in the wider strategic framework.

2.10 p.m.

[78] **Janice Gregory:** That is very helpful. This may not be something you can answer now. You talked about tweaking QOF, but the indicators that you described to us are fundamental. So, I assume that they will remain and you will add more indicators rather than taking away what I regard as fundamental indicators, especially in the constituency that I represent, where there are issues with diabetes and hypertension? I would hate to see those indicators being diluted, so will those remain as fundamental?

[79] **Ms Lloyd:** Yes, they are fundamental. The way that they are described in order to gain QOF points might change, but these are the core of the chronic diseases.

[80] **David Melding:** We have referred to chronic diseases, which are usually lifelong

diseases, although some are long-term diseases. Measures should come through fairly soon should they not if we are achieving improvements, because people will not be suffering complications with diabetes, or strokes if hypertension is the issue? Do you fully expect that in the next two to three years?

[81] **Ms Lloyd:** Yes.

[82] **David Melding:** So you would be able to make some type of statistical analysis?

[83] **Ms Lloyd:** Yes. We are also tracking how you can better manage those at the highest risk within communities. Without the registers and an analysis of what the committee looks like, it is quite difficult to get to those higher risk people. Therefore, as part of 'Informing Healthcare', we have a project ongoing on how, using the database, to identify the people at the highest risk, how to manage those very high risk patients, and what then happens to the entire care model.

[84] **Lesley Griffiths:** I am looking at the enhanced services, and local health boards obviously have to provide directed, enhanced services. National enhanced services are considered important for primary care to deliver. How are these services chosen? Are they aligned to NHS Wales's strategic priorities?

[85] **Mr Sweeney:** They are aligned to NHS strategic priorities, and they take some direction from UK strands. For example, the Disability Rights Commission was instrumental in our discussions to introduce the severe mental health enhanced service and the learning disability enhanced service, which provided for annual checkups. Therefore, we try to align the two. However, they are directed enhanced services from the centre, negotiated with GPC Wales. This overlaps a little with the previous question. In addition to the trade union and its natural wish to support its members, the GP community in Wales—once you get beyond the headlines—is a very dedicated team of people who want to give the best possible service to their patients. One way in which we get the best use out of the contract and enhanced services therefore is by negotiating with them, and, in doing so, we try to reach an agreement on what is deliverable, what will represent good value for public money, and what will support the strategic aims of NHS Wales.

[86] **Lesley Griffiths:** Which enhanced services do you think local health boards would have an eye on to be directed in future?

[87] **Mr Sweeney:** To be directed from the centre?

[88] **Lesley Griffiths:** Yes.

[89] **Mr Sweeney:** The local health boards would possibly prefer us to release the cash to them so that there would be more local enhanced services. That is probably the direction that we should travel in, although I hasten to add that I have not checked that out with Ms Lloyd or the Minister yet. The reason why we had so many directed enhanced services at the start was a lack of confidence on my part and that of others about how this contract would go and what the best way forward was. For example, we wondered whether we should pile more stuff on the LHBs, which, as Ann said, had done magnificently in getting the contract in place. It was followed shortly by the dental contract and the pharmacy contract, so the LHBs did really well. We were worried that we would overburden them, so we kept it central. There is a natural temptation for civil servants to centralise anyway. However, I think that we should now be reaching to get more money out there, but, as I say, those are my own thoughts. I add that for safety reasons.

[90] **David Melding:** We really are having a candid session. [*Laughter*.]

[91] **Helen Mary Jones:** That last point leads me neatly on to the question that I want to ask, which is about locally enhanced services. The report tells us that those are not developing as quickly as was hoped, or envisaged. Can you say a bit more about why so few local health boards have significantly invested in locally enhanced services? Can you also tell us how NHS Wales will encourage local health boards to commission good quality, locally enhanced services—other than by giving them more money, although I am sure they would tell us that that is what they want? However, there may be more to it than that.

[92] **Mr Sweeney:** There is more to it. I do not think that we should downplay the cash side. Accepting what you say, I think that local health boards over the last few years have adjusted to the demands of this contract, and there is a natural hesitance for them to spend money when, as we all know, they are under strict financial constraints. However, this report was compiled largely in the last year. We already see signs—and the report rightly picks up on a few of these—that LHBs themselves are finding their feet and starting to adjust to these things. Partly because they are able to interrogate the IT systems, and find out the make-up of their population in these crucial health categories, we would expect them, and encourage them, to use that data to start devising locally enhanced services that target those people, because it would be foolish to have all this detailed information, for the very first time in the NHS, and not use it in that way. Incidentally, I think that it is capable of being used in far wider fields, but that would be a useful start, and that is where we would encourage them to go.

[93] **Helen Mary Jones:** As for resourcing locally enhanced services, which you have touched on already, is there an issue with moving resources out of secondary care? Does the NHS in Wales have any plans to establish a framework to make it easier to disinvest from secondary care, and reinvest in primary care? There are obviously policy issues there, but I am trying to get at the structural difficulties that make that difficult.

[94] **Ms Lloyd:** If I can answer that, it has been notoriously difficult to get money out of secondary care services, because they will rightly argue, ‘You might be doing that work, but ours has increased as well’. That is why the live models that we will run will be so important—they will show absolutely explicitly where the money needs to be invested for the future, and whether you need some sort of pump-priming money in order to make that change. The Wanless money, which the Minister announced a few years ago, was intended to start to ease the transfer, and we still have that small resource available to us—the Minister is considering how to use that at the moment.

[95] The local enhanced services have had an interesting history. It was often the case, as described to me by the chief executives, that they started commissioning locally enhanced services that happened to be in place already, and were the special interests of general practitioners. Now they are moving away from that, and looking at the work that the National Public Health Service does for them on an annual basis, which means looking at the health needs of their population. They are starting to pinpoint areas that are not covered by directed enhanced services at the moment, and identifying their top priorities for commissioning as local enhanced services. That has caused a problem because, this year, we sent all the money out to the LHBs—we could not reach agreement with the General Practitioners’ Committee on the directed services, and the LHBs have started to use that money more flexibly as a consequence. As John says, I think that they would like to have more responsibility over this.

[96] **Helen Mary Jones:** May I pursue that a bit further? It partly touches on an earlier answer to a question from Chris Franks. Local health boards are small organisations, some of them very small. In your judgment, do they have the capacity, supposing that the resource can be found, to effectively commission more local enhanced services?

2.20 p.m.

[97] **Ms Lloyd:** I think that some of them would struggle, largely because they are preoccupied with other things. That is why we have encouraged them, through a sort of informal national general medical services contract group, to look at ways in which others have been able to utilise local enhanced services better, so that they are not constantly reinventing the wheel, or to join together for certain pieces of work, so that they get a greater competence and confidence in being able to negotiate, given their health needs. LHBs standing absolutely on their own, and trying to do everything, is not the best way to proceed at present. Many of them are already joining up into groups to discuss what they are going to be doing about local enhanced services, and a vast range of other things. We are finding that there is much more co-operation between the management of the LHBs to try to ensure that they can feed off the competence that there might be in another LHB, to help them to succeed with this and other contracts.

[98] **Helen Mary Jones:** You mentioned that much of that co-operative work is happening informally. To ensure that it is consistent, should there be more structure to that work, or is it best done in a more flexible way?

[99] **Ms Lloyd:** They are the ones who are responsible, after all. In some areas of Wales, there is a great formality about this; as you know, in some parts of Wales, one chief executive covers several LHBs. That has brought a real strength to the teams—it does not take away from the localism and the importance of the stakeholder locally and the partners, but it has given that extra ability to grow confidence and competence throughout the system.

[100] I would hesitate to impose any greater rigour in the system at present. However, one thing that we must encourage from the centre is that they recognise that other people are doing this well—and this report is helpful in this instance—and that they should not try to do everything themselves. I think that they are quite sensible, and that they have recognised that. A lot of information sharing is going on out there.

[101] **Eleanor Burnham:** In case anyone has dropped in from Mars, can you tell me what benefit there will be to my constituents in north Wales from local enhanced services provision, because there is a whole mishmash of different categories? You said earlier that it has a historical basis on general practitioners' own interests. What are you doing to improve matters and assure me that we are getting real value for money and benefit for constituents and patients, and not just playing to people's interests?

[102] **David Melding:** I think that they are meant to be fairly variable, are they not, in terms of responding to local need?

[103] **Ms Lloyd:** Yes.

[104] **Mr Sweeney:** Your constituents will be getting the full benefit of all the directed enhanced services. Local enhanced services, as the Chair says, are a matter for each area.

[105] **Eleanor Burnham:** So it is really a carrot for a GP, who may have a particular interest, to improve his quality of life, in that whatever he is really interested in will be served?

[106] **Ms Lloyd:** Not necessarily. If that interest does not reflect a priority need within the community, then it should not be a local enhanced service.

[107] **Chris Franks:** We have focused in the last few minutes on LHBs. I am not particularly confident that the trusts will welcome seeing the loss of resources. Am I being a

pessimist, or do you have something that will say, 'No, the trusts are going to be helpful, and here is a substantial sum of money.'?

[108] **David Melding:** This is a new area. You are welcome to reply if you want, but you would be brave. [*Laughter*.]

[109] **Ms Lloyd:** As a former trust chief executive, I know that you try to hold as much of the pot of gold as you can. However, with chronic disease management causing a major problem for communities, trusts and local health boards, there has to be, and there is, a growing understanding from those trusts in Wales that they will not be providing certain services for the future as they will be provided in the community and the resource will go with them. However, it must be acknowledged exactly what services they will provide and how that will be resourced. We must have a mature discussion. It is a long time since the days of massive competition and the attitude of, 'I am going to be better than you'. Trusts have had a growing understanding of the part that they must play in improving their communities' health, and a lot of good work is going on between local health boards and trusts to find a better and more sustainable care pathway for people in their communities than was the situation five years ago.

[110] **Chris Franks:** You are an optimist.

[111] **Ms Lloyd:** I am an eternal optimist.

[112] **Chris Franks:** The question is which of us is a realist?

[113] **David Melding:** The strategic question is this: in your view, having seen it in operation for a few years, does the new contract provide the ability to transfer more work that is clearly not located in an optimal location in secondary care and that could be done much nearer to where the patient lives, to a setting where the patient will be less anxious, and so on? You seem to be saying 'yes' to that, but can you confirm it?

[114] **Ms Lloyd:** Yes, but it must be underpinned by the right strategies. I believe that we have the right strategies to do that.

[115] **Chris Franks:** Perhaps you can tell us in a year where your optimism has taken you.

[116] **Mr Sweeney:** I think that what has happened here is that anti-coagulation clinics are an example and there are various others, but it probably needs to be accelerated. I am sure that everyone will be interested to see what happens as a result of Dr Chris Jones's venture in north Wales to look at community and primary care services and how that plays out in relation to your question about transferring resources from secondary to primary care.

[117] **Darren Millar:** Moving on to part 2 of the report and some of the changes that might need to be made to the contract, one thing that concerned me when I read the report was the assertion that there was potentially a duplication of payment for some services, because of the loose definition of what a core service is. It is as loose as,

'to provide primary care services to patients who are, or who think they may be ill'.

[118] I do not think that it could be any looser. I appreciate that it was deliberately loose, to allow for an extension of core services, as technology and so on moved on, and different types of care were introduced, but it concerns me that there is a potential duplication and that there is little consistency across the board. One of the examples given is that some GP practices are paid for phlebotomy services, while others are not. Would there be any benefit from tightening up the definition of what is a core service and what is not?

[119] **Mr Sweeney:** There is some duplication, and we have already raised that in the national negotiations, and Northern Ireland, because of a particular issue there, is supportive of looking at this. It is obviously wrong that people should be paid twice. On the other hand, we have not been able to establish that it is as widespread as the report indicates. We accept the principle of it and we accept that it is wrong, but my hunch is that it would cause us more trouble and expense to try to pin down a core definition, for the reasons that the auditor general sets out here, than we would save by the duplication of services. However, we must pursue it, and it is best pursued in UK negotiations, because it affects everyone. You are right that there was a long debate to try to pin the definition down at the time of the negotiations, for the very reasons that you set out. However, the report makes it clear why it was decided to keep it loose.

[120] **Darren Millar:** Taxpayers are obviously concerned whenever they see any potential waste, particularly within the NHS. There is only a limited pot of resources, and if you are not sure how widespread this is, surely it merits much more investigation in order to determine what the level might be, to release those resources for other services.

[121] **Mr Sweeney:** We accept that principle. On the mechanism for pursuing it, we have, so far, taken the view that it is best pursued at UK level, because it affects all four countries, and the definition was established as part of a UK-wide contract.

2.30 p.m.

[122] **Ms Lloyd:** However, I think that there must be consistency within Wales. I would agree with the auditor general that it is essential that the differentials are removed, which is why John Sweeney's department is looking at gathering the information—sharing it with the LHBs—about where there might be duplication and where there is variation in each LHB area.

[123] **Darren Millar:** It is certainly important if you want to develop more of the local enhanced services, is it not? It may well be that an enormous amount of resource is tied up with the duplication of payments.

[124] **Ms Lloyd:** Yes; absolutely.

[125] **David Melding:** Thank you. I do not see that anyone else wants to contribute to this particular point.

[126] **Chris Franks:** I am not going to discuss the Carr-Hill formula, as it might be a bit beyond me, I suspect, but can you comment on the minimum practice income guarantee? How do you see this formula being phased out?

[127] **Mr Sweeney:** It is a difficult problem. I mentioned right at the start of the meeting that this concession was agreed because of the uproar in the GP profession, UK-wide, when GPs saw the results of the first Carr-Hill formula outcome. That minimum practice income guarantee now sits right across the contract in Wales. Some 90 per cent of practices are under that protection, as Ann said earlier, and there is a similar level in the other three countries.

[128] On the Government side, the four health departments certainly agree that it should be removed as a matter of urgency, to allow the redistribution that Carr-Hill wanted from leafy suburbs to deprived areas. However, if we do it too suddenly, we destabilise practices, and it is not in anybody's interest to destabilise any practice, wherever it may be. So, if inflation continued and the global sum continually went up, that would, in turn, depress MPIG, and practices would start to withdraw from it. In the last couple of years, however, there has been

no uplift anyway to that sum, for the reasons that we mentioned earlier, and if we were relying even on inflationary ones, it would take us years to erode MPIG. So, we have a very difficult problem, UK-wide, in trying to devise a formula that will start to erode MPIG without destabilising practices by the sudden implication of a redistribution that would be unsustainable for some practices.

[129] **Chris Franks:** Does this, basically, mean that poorer communities will be subsidising more affluent communities, and that this situation is accepted and will continue many years hence?

[130] **Mr Sweeney:** It is certainly not accepted. Our Minister has made it clear, as have the other UK Ministers, that it is a priority to get rid of MPIG. So, it is not accepted; we accept that the concession made to get the contract through in the first place has now had this undesirable effect. It is a central plank of the UK Government side's negotiating stance from now on. You referred to the complexity of the Carr-Hill formula, but it requires a great deal of careful adjustment by health economists and everybody else to try to move forward in this. It is not an easy problem to solve.

[131] **Chris Franks:** Will it be resolved within five years, or 10 years, do you think?

[132] **Mr Sweeney:** If we allowed it just to go along with inflation, it would take us somewhere between 20 and 30 years, which is obviously ridiculous.

[133] **David Melding:** That is daunting.

[134] **Mr Sweeney:** It is, but there is no intention to do that, Chair, I hasten to add.

[135] **David Melding:** Have I grasped this: MPIG was designed to get people to go into the quality and outcomes framework system? We will explore this a little later, but as it met the QOF targets, or surpassed them, why did MPIG not go, if it was there to give them confidence that their income would not suddenly and drastically reduce? Or have I got that wrong?

[136] **Mr Sweeney:** Yes, I think that you have, Chair. If the global sum transferred across to people for their running costs, such as for staff and associated costs, goes up according to normal inflationary increases, then MPIG comes down. However, if we allow it to be eroded by that factor alone, it will not disappear for 20 or 30 years. So, we must find another way of doing this.

[137] As far as subsidising goes, I suppose that that is a question of how you define it. However, it is certainly true that the present system tends to reward practices in affluent areas more than practices in deprived areas. There is an argument that deprived areas could initially have more QOF points in that part of the contract, because there is more prevalence of disease, but that is a puny compensation.

[138] **David Melding:** So, as QOF payments increased, there was never a connection with the fact that MPIG would be phased out?

[139] **Mr Sweeney:** No.

[140] **Helen Mary Jones:** I was slightly perturbed by the use of the word 'sudden' in this regard. This contract has been in place for some time, and it would be quite difficult to describe any changes that were made to it as 'sudden'. However, I understand the concern about destabilising practices. Has any assessment been made of the extent to which those practices would lose out, because it is unaffordable for the minimum practice income

guarantee to carry on for another 30 years, as it is unaffordable and unrelated to service delivery? Would it be possible to estimate how those practices might lose money if the minimum income guarantee is eventually phased out—no-one is suggesting that it should be taken away overnight? Could that be an incentive for those practices to take up more enhanced services in order to be more proactive about local enhanced services?

[141] **Mr Sweeney:** If we got rid of MPIG and elements of the Carr-Hill formula, those practices could, in time, because they were being rewarded more, build up the staff and invest in training, and place themselves in a better position to take advantage of enhanced services, and so on. The report makes it clear that some practices were not prepared to engage with LHBs on local enhanced services, and I think that that is a question of professional training, and so on. It is possible to do it but it would not happen overnight.

[142] **Helen Mary Jones:** We are all agreed that the 20 to 30 years' timeframe is not acceptable. Is it possible to estimate how long it might take to renegotiate this, because it is a major cost on the primary care system at the moment, which is not a cost that is meeting delivery?

[143] **Mr Sweeney:** I understand the attraction of being able to say to you that this would disappear in five years or so, but I cannot do that, because it is dependent on an erosion formula being devised to try to attack it. All I can say with any confidence is that all four UK health departments have made it their top priority to do this. It is not just a question of finding a formula to do that; it is a question of negotiating with the GP representatives, who will be under competing pressures from their members in poor areas and those who are benefiting at the moment from MPIG.

[144] **Helen Mary Jones:** An enhanced salaried GP scheme might concentrate minds wonderfully.

[145] **Mr Sweeney:** Yes.

[146] **Eleanor Burnham:** In the Carr-Hill resource allocation formula, I noticed that one of the bullet points is about an adjustment for list turnover. Does that mean that if a GP has a high turnover he or she will get an enhancement? Or do you look at why GPs have high list turnovers, such as patients not liking them, or whatever? How do you ensure that you have value for money in qualitative terms and not just in quantitative terms?

[147] **Mr Sweeney:** I would hesitate to take one part of this formula and tell you what it means with any confidence. As regards the general question, LHBs will look closely at high turnover outside the Carr-Hill formula and look at the reasons as to why that happens.

[148] **Eleanor Burnham:** Do they try to address the issue as a result?

[149] **Mr Sweeney:** Yes, I think that they do, as part of their quality agenda to check on how practices go. As far as the Carr-Hill formula is concerned, I am with Mr Franks on this one, I am afraid. [*Laughter.*]

[150] **David Melding:** That is a modest admission; it also gives us some confidence.

2.40 p.m.

[151] **Chris Franks:** Would a GP receive more money if he or she had Eleanor on his or her books? [*Laughter.*]

[152] **Eleanor Burnham:** Thank you, Chris.

[153] **David Melding:** We have touched on this already, but the quality and outcomes framework is now the main performance management guarantee. It is a snapshot now, but how are we going to use QOF to improve standards over time, because what is acceptable now, will be very different in five or 10 years, as it would have been five or 10 years ago. So, how is the framework going to evolve?

[154] **Ms Lloyd:** The framework will evolve given advances in the requirements of the four countries to improve the standards of care available. There is constant discussion between the four countries, given the existing QOF formula, about how many people are meeting it, how we need to extend it, and how it meets our strategies. So, it is constantly moving, in discussion with the General Practitioners Committee and others, to ensure that there is a constant push of improved quality. When the healthcare standards for Wales are rolled out into general practice and the community service, they will be used to drive a change in what is delivered through the QOF. It is iterative and it is constant.

[155] **David Melding:** That is very clear. Irene?

[156] **Irene James:** I would like to look at paragraphs 2.18 to 2.22, under the heading, 'The way in which the contract is managed in Wales must be improved'. There seems to be a large variation across Wales in the way in which the contract is managed. Do you feel that local health boards are failing to manage the contract, and do you think that they have had enough support and guidance in introducing the new contract, and, if they have, why is there such a variation across Wales?

[157] **Ms Lloyd:** We issued comprehensive guidance in 2004 to enable them to manage this contract effectively, and, as I said, it was put in very quickly. That has been enhanced by additional guidance that we have given them on QOF, and we have a general medical services website. So, there is a constant flow of information and advice available to them. There is every requirement—and, in fact, a mandatory requirement—for them to monitor this contract effectively. Some are monitoring it better than others, as you have said. Therefore, we are going to visit those LHBs where there have been problems of monitoring and managing the contract, to ensure that they have the effective skills in order to do this.

[158] They are learning from each other and, as I said before, the Caerphilly LHB model, as outlined here, is an extremely good model. It did not have more resources than the average local health board, and that team is helping us to ensure that the advantages of the scheme that it has initiated and the ways in which it did it are rolled out across Wales. We need to get consistency and to stop people from reinventing the wheel, so that where there is good practice, it should be adopted.

[159] The LHBs have done reasonably well in keeping a handle on this contract and being able to assure us that they are keeping a check on it. Mr Sweeney described what 'high trust' meant—it does not mean to say that they can just get on with it that and no-ones checks. That is not the case, because checking is required. However, we need to ensure that the best ways of doing these important checks are known to all and that they have the confidence to take them up.

[160] **Irene James:** As a Member whose area comes under Caerphilly LHB, I am absolutely delighted to hear what you have to say about it.

[161] **Ms Lloyd:** It is quite creative.

[162] **Irene James:** I am delighted to hear you say that we are not looking for people to reinvent the wheel, because, all too often, that is what someone expects. We need to look at

what is out there and pass it on.

[163] **Helen Mary Jones:** I will come back to my perennial point about the capacity of local health boards. Is the pattern of not administrating this properly connected to the size and, therefore, the capacity of the local health board? Caerphilly LHB has done a fantastic job, but it also covers one of the larger geographical areas. Is that a factor, or is it a question of how resources are used?

[164] **Ms Lloyd:** I am surprised, but I do not think that that is the answer in this instance. Some small LHBs have done some good work. It is an issue of the skills and capacity within individual organisations. That is why we must maximise those skills by ensuring that they can adopt the best practice possible.

[165] **David Melding:** Do you have any practical examples of how you disseminate best practice?

[166] **Mr Sweeney:** We have a website that gives information and we issue guidance where required. We accept all the areas in the report where the auditor general says that we should reinforce, reissue or strengthen guidance. So, we will take that up.

[167] Another way of disseminating good practice is through the informal GMS group that Ms Lloyd mentioned earlier, where I and a couple of my colleagues meet representative chief executives of a local health board from each region. They then disseminate the outcome of that meeting to the other chief executives in their area. It is through that that we are trying to encourage an informal network of good practice so that people can get in touch even if they are separated by the length of Wales.

[168] **Ms Lloyd:** We also have the National Leadership and Innovation Agency for Healthcare, through which innovation is disseminated. Now that it has had a couple of years of running different ways and different systems, these can be included in the work that NLIAH does to ensure that everyone is well aware of it.

[169] **Chris Franks:** You have already covered what I was going to ask in my supplementary. However, my impression is that, bearing in mind the limited staff resources of LHBs, some of them seem to spend a tremendous amount of time focusing on managing the inherited debt that some have enjoyed in the past. When an organisation is trying to balance the books, that could be the major issue. So, how can you assure us that when they were dealing with this financial issue, they still had adequate resources, in personnel terms, to manage this contract?

[170] **Ms Lloyd:** That is a bit of a tangential question.

[171] **David Melding:** It is, but were senior staff involved, for example? Has quality time been spent on the management of health?

[172] **Ms Lloyd:** Yes, I think quality time has been spent. On the point about inherited debt, or debts acquired, unless they manage the resources, then they will never innovate or develop policy because they are constantly struggling to try to manage the debt. Most of the LHBs with whom we have had discussions about their debt—and I will not differentiate between their inherited and their own imposed debt—have had to pay attention to it, because it has largely allowed them to look carefully at how they are matching the needs of their population with the services that they provide. This GMS contract is an important part of that discussion. For example, how are they using the resources that have gone into GMS? Are they maximising the use of the contract? Are they ensuring that a standard quality is being delivered out there, and are they getting value for money? The GMS contract and its

management is part of the discussions on how they are managing their whole resource, regardless of whether or not they have a debt. So, they have known that we would always test them on how they were managing their contracts—and there are several—how they are managing the implementation of strategy and how they are managing their resources. Each of those is as important as the other.

[173] **Darren Millar:** On QOF, the report talks about the potential to be able to manipulate the point-scoring in order to squeeze more cash into the practice. Any kind of manipulation is concerning. England has the system of doing random checks on 5 per cent of practices. Why is this not done in Wales?

2.50 p.m.

[174] **Ms Lloyd:** We will come back to manipulation in a minute, but the guidance insisted on random checks in Wales, and Mr Sweeney will update you on where we have got to.

[175] On paragraph 2.27, if there is any evidence of manipulation, it should be brought to my attention without delay, because it would be very serious and, in order to substantiate or otherwise that particular paragraph, as the accounting officer, I should be made aware of the evidence.

[176] **Darren Millar:** It does not actually suggest that there is manipulation; it is saying that there is potential to manipulate. Those are two very different things.

[177] **Ms Lloyd:** Yes, but I am just saying that if there is evidence, I would like to know.

[178] **Darren Millar:** The point that it is making is that there is insufficient rigour to ensure that there is not manipulation, effectively, is it not?

[179] **Ms Lloyd:** It can be read in a number of ways. What is important is that there must be the rigour, but if there is a problem, I need to know, because I am the accounting officer.

[180] **David Melding:** This is an important issue. We have a high-trust system and there is a risk of manipulation. I do not believe that anyone is denying that; it is accepted. Indeed, there are many high-trust systems out there. This is not uncommon. However, they have quality checks.

[181] **Ms Lloyd:** Of course they do. I have discussed the issue of managing a high-risk system with my local health board chief executives, and, if you want me to describe what they would say to you if they were sitting here, they would say that they are quite clear about how they go about looking at exception reports, which are mentioned in here, and how they go about checking prevalence.

[182] On exception reports, we have had considerable successes in that the exception reporting is coming right down to almost the same level as in England and, where there are exceptions, they are now being tested firmly by the local health boards.

[183] On disease prevalence, which is another issue that comes into this section, the LHBs are greatly helped now by the National Public Health Service, which does their prevalence indices for them every year, so they know what their prevalence is. So, if something is coming up on their high-trust system, which shows that there is a skew in the results, then they bring in those practices and are able to check them much better than they could at the very beginning. The NPHS has done an excellent job in helping them to understand better the prevalence of health needs in their communities, and it has done really in-depth reports for local health boards where there seem to be anomalies on the reality of the prevalence of

particular health needs in their communities so that they are able to get a better grip on the prevalence statistics and their accuracy coming back from GPs' premises.

[184] **Darren Millar:** Going back to this issue of random checks, why did we not have 5 per cent of all practices randomly checked?

[185] **Mr Sweeney:** The point is that these 5 per cent checks are not carried out according to the report. We have already informally said that, as a result of the emerging report, these should be carried out—

[186] **David Melding:** Do you accept that 5 per cent is the appropriate rate?

[187] **Mr Sweeney:** Yes, you could argue that it should be around that. We would be happy to accept 5 per cent.

[188] **David Melding:** Many high-trust systems aim for 10 per cent, for instance.

[189] **Mr Sweeney:** I have already mentioned the high-trust element of this contract. There are information technology systems in place that interrogate the thing; it is not completely left to chance. We accept the principle. We do not have any hang-ups about the percentage. We have not formally issued it because we wanted to see the outcome of this meeting but, certainly informally, we have suggested the need for it.

[190] **David Melding:** That is helpful. I think that we have covered that. Lorraine is next.

[191] **Lorraine Barrett:** I am looking at paragraph 2.33 on primary care estates. Can you describe the impact on service developments of the slow pace of investment in primary estates? We all have examples of struggling doctors' surgeries, like mine, being unable to provide the enhanced services in a very limited space, such as in a terraced house. Can you expand on that?

[192] **Mr Sweeney:** Our current primary care estates scheme has come in for a bit of stick from AMs who have encountered problems in their areas. It is a third-party development scheme, so we use small amounts of revenue over a number of years to support capital developments. The difference between that and the old system—and this is where a lot of the friction comes from—is that, in the past, GPs were able to go to health authorities and say, 'I want to build an extension here'. We took the decision that the primary care estate in Wales needed to be modernised. There was no doubt about it—and you have just described some of the problems. We wanted to do it in a strategic way, which is why we gave the LHBs money to draw up an estates strategy.

[193] There is a problem with process, because people see it as being too complicated. The Minister has asked us to review that and to streamline our position with that of the Design Commission for Wales. However, there is also a conflict with what the LHBs want and what we want to do, which is put the practices in strategic areas in a more planned way rather than have five or six practices in one street and then other areas of a town without any practices at all. You need only take a walk up to north Cardiff to see examples of that. So, there is a basic conflict, because doctors just want to modernise what they are already used to. We are using the primary care estates strategy to replace existing stock, where appropriate. For example, we did that in Betws-y-Coed. We have also been using it to finance big primary care resource centres, which will include GP surgeries and other services, as we have done in Neath Port Talbot, Mountain Ash, and Pembroke Dock. So, it comes in for a bit of stick. The process is probably too complicated, and we are looking at that. However, for the first time, it is an attempt to take a strategic look at primary care and to provide it in those places where we want to see it.

[194] **Darren Millar:** There is a specific example in my constituency of the Design Commission for Wales holding up progress on a GP surgery. It is not for lack of trying, or a case of the local health board not wanting to see the investment made; the problem is purely the hoops that the practice has to jump through in order to deliver. I was heartened by the Minister's comments in the Chamber earlier in the week. I hope that you will look at that. How long will that review take?

[195] **Mr Sweeney:** I have already taken action on what the Minister said. We support the design commission in the sense that, when any public money is invested in buildings, the buildings should be fit for purpose and, where possible, should blend in appropriately with the area. However, we do not think that that should be an obstruction to getting the work done. So, we have said that we will consider those cases that have been sorted out in every other way but in which the only hold-up is gaining the approval of the Design Commission for Wales.

[196] In defence of the design commission, I remember a case in which a building application was turned down for purely practical reasons: it had a flat roof and it was based somewhere in Snowdonia. There were a few things relating to the application that the commission pointed out might not be the best way forward. So, it has not been sitting there trying to impose appropriate colour schemes and so on; a lot of its work is practical. However, I accept that we need to streamline its participation in this scheme, as the Minister said.

[197] **Darren Millar:** There are also capacity issues with the volume of work that it can undertake, are there not?

[198] **Mr Sweeney:** There certainly seem to be.

[199] **Eleanor Burnham:** I would like to come in on this point, because I have been involved in some cases.

[200] **David Melding:** I do not want lots of examples from local constituencies.

[201] **Eleanor Burnham:** No, but on the capacity issue, I was told that the commission has only 10 per cent of what the commission in England has to spend.

[202] **David Melding:** Let us not degenerate into a free-for-all on the capital status; it has to be related to the report.

[203] It is 3 p.m. and we have made good progress, but I want to adjourn for 15 minutes. I anticipate that the rest of the evidence will not take us beyond around 4 p.m. and we may do a bit better than that, so we will reconvene at 3.15 p.m..

Gohiriwyd y cyfarfod rhwng 3.00 p.m. a 3.17 p.m.
The meeting adjourned between 3.00 p.m. and 3.17 p.m.

[204] **David Melding:** I welcome everyone back, as we recommence taking oral evidence on the general medical services contract. We will dive straight back in.

[205] **Eleanor Burnham:** I am absolutely fascinated by the out-of-hours service, and I am delighted that the audit office has focused on provision in Conwy and Denbighshire. We were asked to go to see the opening of this wonderful facility and, on the surface, I was very impressed. I am generally wondering why the NHS in Wales has not put any standard of performance measures in place for out-of-hours services. I presume that there are

discrepancies across the patch, and such measures would surely support LHBs in commissioning the best quality services.

[206] **David Melding:** As well as the best value-for-money deal.

[207] **Ms Lloyd:** Provisional out-of-hours standards were put in place in 2004 when the first contracts were being let. We have reviewed them, and a revised circular is about to be issued as people begin to re-commission their out-of-hours services. So, there were standards and there was guidance.

[208] **Eleanor Burnham:** If people have performed badly, does that mean that they could lose their contracts?

[209] **Ms Lloyd:** If people do not meet the standards, you cannot award them a contract.

[210] **Helen Mary Jones:** I wonder whether you would accept that the aspect of the contract that has caused the most public disquiet has been the perceived big change in out-of-hours provision. I wonder whether you would also accept that there is a huge difference in the quality of provision in one place and another. Are you confident that the new standards to be put in place will ensure that the standard of provision can be driven up to at least an acceptable level across Wales, and then start to improve?

[211] **Ms Lloyd:** I would agree with you that the out-of-hours services have caused considerable public disquiet, particularly at first. I think that one of the big problems was that the general public was totally confused about how to acquire care and attention out of hours in an emergency. There are all sorts of anecdotes about what happened in the first six months, with the service being used inappropriately. Therefore, we have put in place a number of steps that are trying very hard to improve the quality of the service.

3.20 a.m.

[212] We hope that the standards that we have developed from those provisional standards back in 2004 will ensure that all the concerns expressed by the general public and by the practitioners running the service have been addressed. I also think that there will be a great opportunity for out-of-hours services when DECS, the delivering emergency care strategy, is implemented, as it will mean that there will be one point through which people access out-of-hours care in the round. Bringing NHS Direct into the ambulance service, which was done on 1 April, has already started to improve the public's perception of how to access care out of hours in an emergency.

[213] **Janice Gregory:** People had huge concerns about the out-of-hours service at the beginning, and there was a great deal of negative press. If you take Valleys or rural constituencies as an example, you will find that the out-of-hours service centre is often well manned and well respected, as in my area. However, people who live at the top end of a valley, with no access to a car, and so who have to rely on public transport, could not get to that centre easily. You can reach that centre from my house in 5 minutes, but not from those areas, which are usually the most deprived parts of the Valleys. It is no exaggeration to say that it could take up to 45 minutes to reach a centre. I hope that, as we go along, the out-of-hours service—if it is not to be abandoned, which I am sure it will not be—will be enhanced and more patient-focused. Do you have any idea of how the NHS will take into account the fears and opinions of the people who live in these more disadvantaged areas? One obvious option is to site another centre closer to such areas, or at least midway between the main centre and the outlying areas.

[214] **Ms Lloyd:** It is a real concern, because some places will plan access on the basis that

everybody has a car or is fit to drive and can attend a centre that is some distance away. The issues that will come through the patient surveys must be taken into account when looking at the revised out-of-hours service, because there must be equality of access. We must provide an out-of-hours emergency service that is appropriate to people's needs, so that people immediately get advice that will help them, and, if they need further care, they are given clear instructions or told that someone appropriate will go out to visit them. People must be assured that their general medical service has not stopped just because it is 6 p.m. or 10 p.m.. There must be continuity of care. From looking at the numbers of people who come through accident-and-emergency departments and who ring the out-of-hours services, we know that a large number of calls is made between 8 p.m. and midnight. It usually tails off after that time, but we must be able to cater for the needs of patients.

[215] With the GMS contract and the more general out-of-hours services working together better, I would hope that there is more continuity of care. Certainly in the Gwent area, the information technology system that we have developed through the Informing Healthcare programme, where whoever happens to be on call has easy access to the patient's record, is good, because that gives people an assurance that they are at least talking to someone who has their case notes or care plan in front of them, rather than working blindly. I have seen, through our reviews, an improvement in the out-of-hours services right across Wales. Those improvements need to be captured, but we must ensure that people feel as secure about the out-of-hours service as they do about their own GP services.

[216] **Lorraine Barrett:** Do you see any improvement across Wales, although the service and provision vary across the country? Do you feel that people now understand how out-of-hours services work, and are not abusing it as much as anecdotal evidence suggests that they were in the beginning? Do they now understand that it is an emergency service if you cannot wait to see your GP, so that they are not using it like NHS Direct, or to try to jump the queue in the morning?

[217] **Ms Lloyd:** Certainly, in the first six months, the out-of-hours services were being rung for all sorts of extraordinary reasons, and I must say, to give them credit, that they managed that well, and tactfully. So, that crisis has diminished over time. Whether out-of-hours provision throughout Wales is absolutely fit for the purpose intended is another question—I think that we will need to test that against the new standards, because there is variation. The way LHBs have negotiated out-of-hours services will depend on their location. In rural areas the out-of-hours service costs more, because it covers community hospitals, and an extended range of responsibilities and duties, which is perfectly reasonable. However, I would reiterate that we need to be absolutely assured that the out-of-hours service is fit-for-purpose. There is evidence that attendance at accident and emergency departments is still climbing; they are still being used as a safe haven by people who do not understand the system. However, in areas where the out-of-hours service is co-ordinated with accident and emergency, people are being more appropriately directed, and we would wish to encourage that.

[218] **David Melding:** I am keen to move on to the final section, which is on costs, and I do not want Haydn's Farewell Symphony to start at that point, so let us turn to part 3 of the report, and the costs of the new contract.

[219] **Janice Gregory:** You can see from part 3 of the report that more money has been spent on the contract than was originally forecast. In fact, it is £17 million more. The intention was to spend 'at least 33 per cent' above the baseline; it was later revised to 38 per cent, which took in extra funding from the Treasury. That was necessary due to the increase in the cost of pensions, and the increased profit premium. However, the actual spend was 44 per cent, and as I said, that amounts to £17 million more than the 2002-03 costings. We have just spoken about out-of-hours services—the costs for those were higher, but were not such a big

percentage of the total. The report says that GPs gave up £6,000 each in withdrawing out-of-hours cover. That was then re-allocated to the LHBs, but the true cost of providing those services was somewhere in the region of £16,500, so there was a substantial shortfall there. Have you any idea why the contract cost so much more than was planned? Do you think that it represents value for money?

[220] **Ms Lloyd:** The main reason for the overspend was the QOF payments, and the QOF points being realised much faster than we expected. The advice at the time, from all four countries' professionals, was that we anticipated that the contractors would reach around 700 points, and of course they went over that, so the vast majority of the overspend was due to QOF points, with out-of-hours being less of a factor. To put it into context, over three years that represented a 3.7 per cent overspend, which might not be desirable, but when you consider that England overspent by 9 per cent, and Northern Ireland by 14 per cent, we managed it better than them. We feel that the QOF payments caused the overspend, but QOF was focused on improved quality, and we achieved improved quality from the beginning. There are a variety of reasons for that. Therefore, in retrospect, you can come up with all the reasons that are outlined in this report, but the four countries agreed on the expected levels, with all the professional advice that they could muster, and we underestimated by 3.7 per cent over three years.

3.30 p.m.

[221] **David Melding:** I do not want to be mean about this, but did Scotland do a bit better than us? They were left out of your comparison. It may be my suspicious Conservative mind. [*Laughter*.]

[222] **Ms Lloyd:** Yes, possibly. I should not think so—Scotland will not release its figures.

[223] **Mr Sweeney:** There is a dispute about the Scottish figures. We are an argumentative race, Chair. [*Laughter*.]

[224] **David Melding:** We cannot question that from you, John. [*Laughter*.]

[225] **Ms Lloyd:** The other thing that is important to note is that the overall GMS spend, as calculated for 2007-08, is about 8.19 per cent; in 1999-2000, it was 9.02 per cent. Therefore, the overall proportion of spend has gone down over the past 10 years—it has not escalated upwards. We do not like to overspend, but on this occasion it was on something that indicated an improvement in quality, which was what we were trying to achieve from this.

[226] **Darren Millar:** You have already explained to us, as the report does, that the primary reason for the overspend was that the GP practices were scoring much higher than the QOF forecast had predicted. Why do you believe the forecast was so outrageously wrong?

[227] **Mr Sweeney:** I do not think that it was outrageously wrong. It was certainly achieved much faster than the central negotiations had indicated to us. However, we were told all along—as was the whole of the UK Government side—that these targets would be hard to achieve, and an independent group that advised those central negotiations said that. I suppose that the suspicion is, in the atmosphere that we described earlier, which gave rise to the MPIG, that there might have been less rigorous standards applied than might have been the case. However, I do not think that that was the case.

[228] The advice was that these would be reasonably challenging standards for GPs to meet. Since then, I think that it is generally accepted that they were too easy for them to meet—the report makes that point, and I think that we knew that anyway. However, great steps have been made UK-wide to address that; QOF points are now harder to achieve, and a

new element has been put into QOF to tighten that up—I believe that you have all seen that over the years. There has also been zero increase in the basic costs, as I mentioned. I think that the report mentions the Doctors' and Dentists' Review Body element of that.

[229] **Darren Millar:** Following on from that, why were no warnings—even informal warnings—or statements issued about the likely outcome in terms of the overspend? Was this flagged up anywhere, as the scores were coming in from the individual practices, and as they were being collated and it was clear that there was going to be a significantly higher score for most practices than had been anticipated? Where was this flagged up?

[230] **Mr Sweeney:** I believe that it was flagged up; you have to wait until the evidence accumulates, and is presented formally to you. When the QOF outcome was put out, it was then at the central negotiation that the NHS Confederation negotiators were instructed to take a harder line by the four health departments. However, we can only work when the evidence is there. Certainly, as the contract started, there was anecdotal evidence, but you cannot reverse a whole just-signed, UK-wide contract on the basis of a few elements of evidence from across the country.

[231] **Chris Franks:** We are aware that this is a UK-wide contract. There is a suspicion that some of the expert advice that was given was rather heavily focused on big, metropolitan GP surgeries, and service in some of those areas might be disappointing, shall we say, and did not really reflect the situation in Wales. Therefore, we almost have a situation where the doctors have hit the targets but are being blamed for doing a good job. If the situation was the other way around, and they had not hit the targets, they would be criticised. Therefore, they are damned if they do and damned if they do not. Was the basis of the advice right? Was it slanted too much towards metropolitan areas, and was the different situation in places such as Wales ignored?

[232] **David Melding:** It is an interesting question. If that were true, devolution has not helped us and the weight of the English experience has distorted the system.

[233] **Mr Sweeney:** That is probably true in any UK-wide negotiation. The respective strength and size of England compared to the other countries creates that juggernaut that I mentioned earlier. As for doctors being damned if they do and damned if they do not, we have never criticised GPs. Whatever newspaper headlines there have been over the last three or four months, they have not originated from the Welsh Assembly Government or its Ministers. We have argued with the GP Committee for Wales on individual issues, some contractual, some not, and we have sometimes fought on those issues in public pages, but we have never criticised GPC Wales or individual GPs, because we believe that, overall, they are a dedicated group of professionals doing a good job. I wanted to put that on the record, Chair.

[234] As regards being too slanted towards metropolitan areas and London in particular, that is possibly a fair point. I do not think that there was much that we could have done about it in the context of the contract, but Wales's interests were certainly not ignored, which was your point. Wales's interests were well safeguarded, to the best of our ability. However, you are certainly right that it is difficult to withstand the huge pressure that England can bring to bear on discussions. That is a fact of life in all UK negotiations.

[235] **Ms Lloyd:** We took advice from our Chief Medical Officer and it did not vary from the advice that came from other parts of the country. So, our voice was heard and it was based on the advice that we were getting from our advisers too.

[236] **Helen Mary Jones:** In terms of the value for money that this contract provides or does not provide in terms of driving up patient care, and taking on board what has been said about the English juggernaut that tends to drive UK negotiations—without asking you to have

a view about whether it would be right to do this or not—were the Minister so minded, could she negotiate different elements in the contract in Wales that might address some of our differences? These differences would be around some of the issues of rurality that we have, which might be a higher priority for us, or some of the particular issues in the former coalfield communities. I am not asking you to have a view about whether that would be a good thing to do, but, subject to the agreement of GPs in Wales, could the Minister do that if she were so minded?

[237] **Mr Sweeney:** It could be done in principle. In effect, it would mean a Wales contract instead of an UK contract, even if you took elements of it. My opinion is that the restricting factor on that is not the capacity of the LHBs, for a change, but civil service capacity to negotiate that, because we are still comparatively small and this is a hugely complex area, but it could be done in principle. Ministers have, from time to time, given the frustrations that arise with primary care and so on, been tempted to go along that route. We could certainly do it, but we would have resource problems, because it is a very intense and complicated issue to tackle, and you run risks of destabilisation that you do not want to run, but, properly resourced, we could have a good crack at it.

[238] **Ms Lloyd:** We have flexibility in the enhanced services to start to move some of that.

[239] **Helen Mary Jones:** I should stress, Chair, that I am not necessarily advocating that, I am just exploring whether that might be an option if, as the contract progresses, the Assembly Government were to feel that that metropolitan juggernaut was not just driving it, but had actually gone off the rails, to mix my metaphors.

[240] **David Melding:** As no other Members wish to contribute, that concludes our evidence gathering session. On behalf of the committee, I thank our witnesses, Ann Lloyd and John Sweeney, for what I think that we all consider to be full and frank answers. That has been very helpful to us.

3.40 p.m.

Rhaglen Archwiliadau Gwerth am Arian Archwilydd Cyffredinol Cymru
The Auditor General for Wales's Programme of Value for Money Examinations

[241] **David Melding:** This is item 3 of the 12 items that we have to deal with. I suspect that we may go a little quicker through the remainder of the agenda. We now look at the Auditor General for Wales's programme of value for money examinations intended for 2008-09. Members will have received the paper, which is paper 2. I invite Jeremy to introduce his paper.

[242] **Mr Colman:** Thank you, Chair. This is, in part, a formal process and, in part, an informal one. Formally, I am required to consult you on the way in which I exercise my powers to carry out examinations of the economy, efficiency and effectiveness with which bodies have used their resources. You are now being consulted. Informally, I thought that it would be helpful to set that formal process in the context of all the work that we are doing in the Wales Audit Office that might come to this committee's attention, which actually goes a bit wider than the area on which I am statutorily obliged to consult you.

[243] This is the beginning of a consultation, and not the end of a consultation, so I have presented in this paper a very long list of potential topics. It would be neither possible nor even wise, perhaps, to do them all. I am very interested in your opinions as to whether we have the right things in the list and, even though the list is already very long, whether there are any additions to which you would wish me to give priority. As this is the beginning of a consultation, some of the projects are not necessarily very closely defined. The breadth of the

scope of some might be too wide and could be narrowed; I will report back to the committee in due course as to my conclusions at the end of this process.

[244] In particular, with regard to the subjects under the heading of health and social services, as well as having a choice of topic and a choice of breadth of topic, in that area, in particular, there are choices that we can exercise as to where the work is done. So, it can be done as a central piece of work that is presented to this committee, and in some cases, these tasks can also be done, or done instead, as local pieces of work, paid for by fees levied on the bodies affected. So, there are many choices about how we do it, but this is all really to assure you that this is the beginning of a consultation. The main purpose of presenting these is to enable you to see the ideas that are in our minds and to hear your views about anything else that you might put in.

[245] **David Melding:** Thank you, Jeremy. So, there are items there to which we may want to add some weight if we feel them to be particularly important, and there may be items to add to this long list that have not occurred to the auditor general yet, and with which we can help him by giving him some issues to consider. Annex 3 is the vital annex before us.

[246] **Lorraine Barrett:** What do you want from us in this regard, Chair? I have an interest in two particular issues, and I would just like to say something about them and share my thoughts about them. Looking at violence against NHS staff, which is number 4, I am thinking of the work of Professor John Sheppard of Cardiff, who did some pioneering work with Alun Michael MP many years ago. That really changed how resources are used and the way in which violence against NHS is targeted through partnership with the police and local authorities. They have a system whereby, when someone is admitted to an accident and emergency department, they can anonymously give information about how they were attacked or what situation they were in without getting themselves into any more trouble than they may already be in. The information is collated and the police and the local authority community safety partnership work on that particular area to target resources. That could, and should, be rolled out across Wales and the UK. I would be interested to see a bit more work done on the cost-effectiveness of that, as well as more safety for our staff.

[247] The other issue is point 15, on working with the voluntary sector. It is a huge minefield, and it is something that has been on my mind for a few years, as I represent an area with a high black and ethnic minority community. Many grants and much public money go into great work that goes on which is done by many people. I have spoken to some BME groups about this, but you can also apply it to the voluntary sector. How can I be convinced that it is good value for money in that it is delivering the outcomes, to use the jargon, and that there is no duplication? In working with certain groups, it is very hard to do that, because you do not want to offend people—many people are doing good work. However, it is still public money that may or may not be being used to best effect. That is something in which I am interested, but can you be more specific about it? How would you gauge spending in the voluntary sector?

[248] **David Melding:** I understand that violence against NHS staff could be follow-up work. It is important that follow-up work is done in vital areas, so that we can measure better performance. I understand that Janice's committee will look at the role of the voluntary sector, which means that there might be a fruitful crossover there.

[249] **Eleanor Burnham:** I would like to ask about Arts Council of Wales capital projects, which is in annex 1, on page 6. I realise that you are looking at capital projects, but in view of the situation that has arisen at the Wales Millennium Centre, is there any possibility of weaving in the WMC's—

[250] **Mr Colman:** It is on the top of the next page.

[251] **Eleanor Burnham:** I am sorry; I had obviously not read that properly. Moving to annex 3, progress with the Welsh housing strategy is a topical issue in terms of homelessness, affordable housing, and so on. Is the list that you have on this page in pecking order?

[252] **Mr Colman:** No.

[253] **Eleanor Burnham:** I have a few other points. Others might not agree, but raising attainment and individual standards in education is topical, particularly in view of the recent debacle in Denbighshire. Late payments to farmers is also another important issue in terms of foot and mouth disease and the lack of money that appears to be available from the Treasury or the Department for Environment, Food and Rural Affairs, because it was DEFRA's mistake. The final issue, which is dear to my heart, is 'Iaith Pawb', to create a bilingual Wales.

[254] **David Melding:** I would endorse raising attainment and individual standards in education—that seems to be key for outcomes, particularly among children who may be having difficulties with skills.

[255] **Eleanor Burnham:** The reason why I asked about farmers is that there are several areas of payment—

[256] **David Melding:** My choice is to endorse the education issue, otherwise we will have a huge list.

[257] **Helen Mary Jones:** Looking at the list of new possible examinations, it seems that there are two that may have bearing on the Government's legislative programme and the Assembly's scrutiny of it. One possible examination is 'Iaith Pawb' and the proposed legislative competence Order to bring additional powers to the Assembly. The other is that the follow-up work on clinical negligence might help to assess the issue around any additional costs of the proposed NHS Redress (Wales) Measure. To look again at what is happening with that might be very useful, and it might be a fairly manageable piece of work, since it is a follow up. I think that, at some point, the dental contract will have to be looked at again. It throws up as many issues, although different ones, as we have been discussing this afternoon.

3.50 p.m.

[258] The final issue that I was pleased to see here, which I hope can be included, is that of compliance with equalities legislation. I sense a major financial risk to public authorities—we only have to consider what has happened with equal pay—if this is not done and claims are taken. It might be useful to look at this, but I also think that there are issues about the capacity of the new single commission to pursue enforcement. Depending on timing, you may be able to get a snapshot of what is happening now that the new commission is in place, or, if it is a bit further down the line, of whether it has had any impact on enforcement and on the advice, support and encouragement that public bodies in Wales receive to enable them to meet their equalities requirement. We obviously would not be reviewing the commission itself, because it is non-devolved, but there is a concern that some of the work that the previous commissions were doing may be lost in the new scenario. It would be useful to get some objective evidence, rather than anecdotal evidence, to see whether that is happening.

[259] **Darren Millar:** I find the number of different topics on this list very interesting, and no doubt there are huge lists elsewhere that you have got up your sleeve, Jeremy. I am particularly pleased to see that field work is under way on flood risk management, which has had a particularly high profile over the summer. Clearly, there are problems out there and it would be interesting to see the outcomes of that, particularly in terms of whether the

necessary investment is going into flood defences. I look forward to seeing that. Can you tell us when you expect to complete that work and when you expect to be able to report?

[260] **Mr Colman:** I am always extremely cautious in predicting when these pieces of work are going to be finished, and the reason for that, as I explained to the committee at a previous meeting, is that our reports are cleared in draft to ensure that they are factually accurate. That process can take a long time. It is not exactly a scientific correlation, but it can take much longer to clear a very critical report than it might take to clear one that is not. We began this work on flooding before the summer, so I hope to bring it forward in the early part of next year, but there is a risk attached to that estimate.

[261] **Darren Millar:** I appreciate that. The second issue that interested me was the forward work programme, and it would be good to see the study of the relocation strategy brought forward. There is still a lot of animosity in certain parts of Wales towards the Assembly, because of its remoteness, geographically, to north Wales. It would be good if that was brought forward so that we could sink our teeth into it as soon as possible.

[262] **Chris Franks:** Being a new boy, I am not quite sure of the form, but I take it that piping up and saying that we are interested in something is the appropriate thing to do?

[263] **David Melding:** It gives weight to the possibility that it will be taken forward. The auditor general is independent, however deferential he is to you. [*Laughter*.] It is his and his team's decision.

[264] **Chris Franks:** I will choose my words carefully. I would like to express my interest in point 28, on selling Wales; the sum of £25 million seems like a lot, but on the other hand, it might not be very much. I am also interested in point 32, on maximising the benefits of major sporting events. Sometimes I receive conflicting messages on this. Two thirds of the population of the country seem to be in Cardiff for sporting events and you imagine a great deal of money pouring in, but, on the other hand, you have organisations saying that we are not selling ourselves enough. So, are we missing opportunities? I will leave it there.

[265] **Janice Gregory:** I have seven choices with one in reserve. That will teach me for reading the papers. I am quite relaxed, because I think that they are all important; they may not be equally important in my eyes, but they are all important and I would be more than content for us to take up any of these. However, how will you decide? My question was going to be posed to the Chair in terms of how he was going to decide what to pass on to you as our views. With the exception of one, my choices are completely different to everyone else's. I agree with the choice of violence against NHS staff, but that is a follow-up. I tried to stay away from the other follow-ups and choose new investigations. I was interested in unscheduled care—we need to look at that. I am also interested in dental services, although that was not one of my choices. So, I will just go through them like the lottery: they are 4, 7, 9, 18, 20, 31 and 38, with 25 as the bonus ball.

[266] **David Melding:** Do read the titles for the record.

[267] **Janice Gregory:** They are violence against NHS staff, unscheduled care, the performance management arrangements in health and social care, free breakfasts in primary schools—I know of the impact that they have in my constituency and I think that that will be worth looking at—the implementation of the foundation phase, and the arts and culture touring and lending initiative, which interested me because I would like to know exactly what it is. There is also the Assembly Government's relocation strategy; again, being a constituency AM representing disadvantaged areas, I would have liked to have seen that. Number 25 is on developing markets for Welsh food products, because I would like to know what the supermarkets and manufacturers are doing about the identification of products made

in Wales and how they can sell those on the supermarkets' shelves. A couple of supermarkets already do this, but I have harped on about this for the last eight years because I have a toilet-paper manufacturer in my constituency and it is surprising how many people do not know that it is manufactured locally. However, I am relaxed about the choice.

[268] **David Melding:** It is now Irene's turn; she has been waiting most patiently.

[269] **Irene James:** Thank you, Chair. I must say that even though we are sat next to each other, there is a space between us, so Janice and I have not cribbed because I have actually written down: who on earth will make this decision because we all have our own preferences? So, do we pass that over to you, Chair?

[270] **David Melding:** No, it is not my decision.

[271] **Irene James:** My preferences also include tackling violence against NHS staff; that is an absolute priority. To echo Janice, I would choose early years education, and something else that I am concerned about, particularly in my constituency, which is tackling substance misuse. However, looking at it, it says that perhaps that is too early, so I will bow and defer to superior information, if that is the best way to put it.

[272] **Lorraine Barrett:** I raise a point of clarification because I do not think that I had my glasses on properly. I did not quite explain, but on violence against NHS staff, Professor John Shepherd's work looked more specifically at the impact of violence on the NHS and the issue of drinking glasses. There is a rule in Cardiff that after 12 p.m. you can only use plastic glasses in clubs. Most of the injuries caused by violence attended to at accident and emergency departments are alcohol related, so, using plastic glasses would reduce the number of injuries and there would be less of an impact in terms of violence against NHS staff. Therefore, that is a two-fold piece of work and I wondered whether those could be linked.

[273] **David Melding:** We understand the process and we have given weight to items. In fact, I do not think that there were omissions. It is interesting that the list seems to get general agreement in that sense. Several items were repeated by different Members. This information is helpful to Jeremy and his team, but the final decisions are theirs to make. However, it is fair to say that they are not made at random. Our interest is noted. Jeremy, do you want to respond?

4.00 p.m.

[274] **Mr Colman:** I will say a little about the process. As you rightly say, Chair, the decision on what I do is mine and mine alone, and I am not even required to give reasons, believe it or not. So, I will take the decisions. Although the word 'programme' appears on the agenda, the paper before you does not use that word, because I do not really approve of the idea that I determine a programme of activity for years ahead. It is very important that we are able to respond at short notice to things that come up. How do things come up? One of the ways is through Members of this committee, or anyone, really. However, this is by no means your only opportunity to influence what I do. If there is a burning issue that you think we should look at that takes priority over everything else in this list even I am prepared to consider that at any time. So, it is a flexible process. The Chair was right to say that your giving weight individually to particular things is really helpful, because it is something that I want to achieve, if possible. I would like to provide the committee with reports on subjects that you are interested in, rather than things that I am interested in.

[275] **David Melding:** That is clear. I think that we are all coming to the view that it is a good partnership, as we become more experienced. I do not think that we have any long-serving members of the committee, though a few have served previously.

4.02 p.m.

Amcangyfrif Archwilydd Cyffredinol Cymru o Incwm a Gwariant Swyddfa Archwilio Cymru ar gyfer y Flwyddyn yn Diweddu 31 Mawrth 2009
The Auditor General for Wales's Estimate of the Income and Expenses of the Wales Audit Office for the Year Ending 31 March 2009

[276] **David Melding:** We have a slightly more influential role here in terms of endorsing it and then laying it with whatever modifications, if any, we think fit before the Assembly. We are looking at paper 3, which I am sure we have all had a chance to read. However, I will ask Jeremy to introduce his estimate before I invite any comments on that.

[277] **Mr Colman:** Thank you very much, Chair. You are right to say that this is a matter on which I have very little say whatsoever; the committee has it all, because I am asking you to approve this estimate.

[278] First, I draw your attention to table 1 on page 3 of the paper. I will explain these figures. These are the crucial figures that you are being asked to approve. The £4.9 million at the top of table 1 is, in effect, a proposed grant from the Assembly to my office for the purposes described in the paper. In addition to that grant, we levy fees on audited bodies, and the fees that are levied on Assembly Government bodies and the NHS constitute the £9.3 million, which is the second figure in table 1. So, that is the total. The third figure, which, by coincidence, is also £4.9 million, is the amount of cash; it is an arithmetical consequence of the figure at the top of the table. That is how much I am asking for.

[279] Why do I need it, why is it more than for the current year, and how can I assure you that it is needed and will be spent wisely? It is needed for two purposes, one of which is that, like everyone else, we face increasing costs as a result of inflation. However, against that, we are able to make some efficiency savings. So, there is a relatively small amount in here for that. The predominant reason for the increase that I am asking for is that I foresee that there will be an increased demand for work from my office in the next year.

[280] If you look at page 7, you will see that I have set out some of the drivers of that increased demand, primarily the consequences of the new constitutional arrangements, which is the first item. These did not particularly change the role of the audit committee, but they very considerably changed the role of the other committees. I foresee that there will be demand for work from my office in support of those committees. Indeed, the Chair has just drawn attention to a particular example of a piece of work being started by one committee that could draw on work that I might otherwise have done for this committee. I have already had other demands from committees and complied with them. There was no money in my budget to do that this year, but we found a way. I would prefer to provide in the budget for a level of demand for work of that kind. It is not possible to predict how much of this work there will be. What I should say is that, for this part of my budget, which is the part that is the concern of this committee, it is an estimate that must not be exceeded, but if I spend less, then the surplus is returned to the Welsh consolidated fund at the end of the year. I do not keep it as reserve funds or anything of that kind.

[281] There are some other reasons why I am seeking money for additional work. The second one is a curious one, in a way. The rationale for setting up the Wales Audit Office was to have a single audit institution capable of looking across the whole of the public sector without being constrained by organisational boundaries. It is therefore fundamental to our achieving our purpose that we do work that will have an impact, of a cross-cutting and whole-systems kind. In the next fortnight, I will be publishing a linked series of four reports on

delayed transfers of care, which is a very fine example of a cross-cutting and whole-systems subject that needs attention. Financing these reports has been a nightmare because under the current arrangements, I have to levy fees on every public body that is covered by those reports. So, one has a negotiation with each one of them about whether or not they should be asked to pay for this work. The delayed transfers of care project has indeed been financed and I hope that everyone will regard it as a fine piece of work. It is not really a very sensible way of financing that kind of project and I would prefer to finance some of it directly by the means of this committee.

[282] Turning to other items, I draw attention to attending to short-notice requests. I emphasised in our previous agenda item that it is very important for the audit office to be able to produce work at short notice, in response to circumstances as they arise. A major example of that was last year's inquiry into the ambulance service, which was done at no extra cost to the Assembly. I did it from within my budget by postponing other work. I would not want to do that very often, although I was delighted to do it on that occasion. I have asked for a little bit more money in this budget to cover that kind of thing, to give a little more room for manoeuvre.

[283] That is predominantly why I am asking for proportionately more than you might expect this year. On the question of the assurance that this money will be well spent, I am now very used to being asked—sometimes in English, sometimes in Latin and sometimes in Welsh—who audits the auditors. Of course, as the committee is very well aware, the accounts of the Wales Audit Office are audited by auditors appointed by the National Assembly. So, the accounts are straight. Most of this afternoon has been concerned with audit work that is not the audit of accounts, but is the audit of value for money.

4.10 p.m.

[284] I want to put on the record that if this committee wishes, at any time, to commission a value-for-money study of some aspect of the Wales Audit Office, I would welcome that. Another possibility—rather than an alternative, because you could certainly have both—would be a peer review carried out by another audit institution. I would be very happy with either or both of those at the appropriate time, although not this week, if you do not mind.

[285] **Janice Gregory:** What about next week? [*Laughter*.]

[286] **Mr Colman:** The Wales Audit Office is still very new, but when we are a little more established, I would welcome that kind of scrutiny.

[287] **David Melding:** Thank you, Jeremy. For the record, the sum requested as an increase is £600,000. I was about to ask you to go through the main reasons and drivers for this extra demand, which I think would take our contribution up to £4.9 million. However, I think that you have outlined that very clearly, so I will not repeat the question.

[288] **Darren Millar:** First of all, £600,000 is a lot of money, but I think that Jeremy has outlined the need for this investment in the Wales Audit Office very clearly. I also welcome his suggestion of having an independent or peer review at some point—an audit of the auditor—which might be appropriate. Next year might be an opportune time to do that, given that it will be three years since the merger of the two audit functions in Wales. There is always the question of whether there is an opportunity cost, and whether the £600,000 should be invested elsewhere. However, I must say that, given the savings and efficiencies that Jeremy regularly identifies in the reports that are published, I cannot think of a better area on which to spend this money, particularly given that any unspent resources on the committee-type work that Jeremy has made provision for will be pooled back into the central pot. Therefore, I would have no hesitation in supporting that request.

[289] **Eleanor Burnham:** I am equally interested in being able to show that we have scrutinised you effectively, as we are a very open and transparent body. I am concerned about the way in which your cross-cutting and whole-service projects require complex fee negotiations. Have you given much thought to how that could be simplified so that you achieve greater cost benefit for your institution, thus saving us from having to give you the extra £600,000 in future?

[290] **David Melding:** I suppose that it is public money, whichever way it comes to you.

[291] **Eleanor Burnham:** I think that you get the gist of the question.

[292] **Mr Colman:** The current situation is that, where there is a really important cross-cutting issue that needs to be examined—and delayed transfers of care clearly fall into that category—it is worth getting that done by whatever means available. Currently, the only means available are what I described: a discussion, indeed negotiation, with literally dozens of public bodies. It is worth doing if it is a really important subject; however, for some cross-cutting subjects, you could say that it would be nice and really important to do it, but you would have to ask yourself whether you could really face another round of negotiations with all of those finance directors. So, there is a slight disincentive for doing what we were set up to do. It is a deficiency in the structure that one has to look to individual bodies to finance that kind of work.

[293] You will see that, on the local government side of the business, I am forecasting—and it is purely a forecast—a decline in real terms in our fee income. That is partly related to the fact that the case for doing more work for individual bodies is declining, as the risks in some cases are reducing, but the case for doing cross-cutting and whole-systems work is increasing. So, some sort of rebalancing is a good thing to try to do.

[294] **Janice Gregory:** Thank you, Jeremy, for the paper, which is very comprehensive—£600,000 of public money is a fair old chunk, and I am glad that you laid it out as you have.

[295] I do not think that these will be particularly awkward questions, but, to my mind, these budgets are certainly not just plucked from trees. Obviously, a certain amount of work must go into the calculation of these figures, so that you arrive at the figures having gone through some consultation. I recall speaking to my trade union colleagues about last year's budget negotiations, and they asked to be kept in the consultation process. Could you confirm that that is the case? Did you consult widely within your own organisation, and with others that you had to, as well as taking out your calculator and thinking about what you wanted to do?

[296] The other question that I have for you is about the job evaluation in paragraph 25. We are all conscious of the equal-pay issue, and rightly so. I have read and re-read the paragraph, and I would love to think that, once you have concluded the job evaluation, it will be cost-neutral. If that is the case, you will be the first organisation in the history of the world to achieve that, so I have some concerns there. I know that you say that the job evaluation will be completed, hopefully, in April 2008, but Darren is right in that you have your third anniversary next June, and so I just wonder why a job evaluation is taking this long. Could we not have staged it over the three years?

[297] **Mr Colman:** I can answer that question very easily. When I arrived, a little more than two and a half years ago, there was some pressure from our unions to conduct a job evaluation immediately, because everyone was aware that we were merging two organisations whose pay regimes were quite different, and there might have been anomalies that needed to be corrected. I resisted that because we were not simply putting two organisations together; I

had plans, which I have subsequently implemented, for a fundamental reorganisation of the new Wales Audit Office, and its organisational structure is now completely different from that of either of the precursor bodies. It seemed to me that it would be nonsense to do a job evaluation when we were in the process of changing everyone's job. Therefore, we would do the change first and then, when that was completed—although that is an exaggeration, as reorganisations are never complete—or when the new structure was in place, that would be the time to have a job evaluation, and to sort out any anomalies that might exist. That is why we are doing it now, and not earlier.

[298] I am pretty confident that the process of job evaluation will be done by April, but I have never said that the financial results of that would be implemented overnight. I could not say that, because this meeting will confirm how much money I have, and the job evaluation process, over the coming months, will identify how much I will need over time. The job evaluation is also part of a reward strategy for the organisation, so it is not to be rushed.

[299] It would not be prudent to budget on the assumption that the job evaluation next year will cost nothing. I have made allowance for that. If you asked me to guess whether the job evaluation will show up a large problem, my guess would be that it will not—and I might be proved wrong, because it is only guessing. My perception is that there are some, but not many, anomalies between some individuals in the organisation. I would be horrified and astonished if there were any anomalies of the kind that caused so much difficulty in the local government sector. I just could not see how that could arise. It would be remarkable.

4.20 p.m.

[300] On whether our salaries are below or above the market, we do not currently have any great difficulty in recruiting, and we do not have a high wastage rate. That suggests that we are not grossly underpaying our staff—though I am sure that my union colleagues would tell us that we were, but you would expect them to say that.

[301] On consultation, I do not think it appropriate for me to consult the unions on this estimate, as it includes a negotiating position for pay negotiations that would be given away by consulting. I look forward to a negotiation with our unions in the coming months as to next year's pay, but that is contained within the figures in this paper.

[302] **Helen Mary Jones:** In my experience of working for the Equal Opportunities Commission, I found that people were always astonished to discover that their job evaluation systems threw up gender discrepancies. So, if you find any—and I am not saying that you will—you would not be the first person to be surprised by them. However, that is not my main point.

[303] I wanted to refer to what you said about the new constitutional arrangements. That is a strong argument for increased resources. If the other scrutiny committees are to scrutinise as effectively as they want to, I am sure that we will want to call on the services of the auditor general. The new Children and Young People Committee has not yet met, but I can already think of about six things that it might ask you to do—whether you can do them or not is another matter. So, I wish to put on record that my party and I believe that that is a strong argument for giving the additional resources at this time. We may find that, in future years, there is further need to provide additional resourcing.

[304] **David Melding:** That is our negotiating position. [*Laughter*.]

[305] **Helen Mary Jones:** I do not want to *mynd o flaen gofid*, or raise problems, at this stage, but that is an important argument, and it is one that is difficult to measure until the new constitutional arrangements have settled in.

David Melding: I do not see anyone else wishing to contribute. Therefore, the proposition is that we endorse the budget estimate before us. I do not see any dissent, so it is endorsed.

4.22 p.m.

Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio, Gwasanaethau Ambiwlans yng Nghymru, Gohebiaeth gan y Pwyllgor Iechyd, Lles a Llywodraeth Leol a Chyngor gan Archwilydd Cyffredinol Cymru
The Welsh Assembly Government's Response to the Audit Committee Report on Ambulance Services in Wales, Correspondence from the Health, Wellbeing and Local Government Committee and Advice from the Auditor General for Wales

[306] **David Melding:** Item 5 relates to papers 4, 5 and 6. Do you wish to bring anything to the committee's attention, Jeremy?

[307] **Mr Colman:** This is slightly more complicated than usual, but that is not a bad thing. The Chair of the Health, Wellbeing and Local Government Committee has written with its observations on the Assembly Government's response to this committee's report on ambulance services in Wales. In my letter, I express a lot of sympathy with most of the points made in that letter. However, on action, I suggest that we in the Wales Audit Office follow up the work done on the Welsh Ambulance Services NHS Trust. It was one of my own recommendations that the new management team at the ambulance trust be given an opportunity to do its job before having auditors breathing down its neck, which it has welcomed. That expires in the next year or so, and we need to see how it is getting along. The performance information from the ambulance trust so far is extremely encouraging, but that is no reason for postponing a look at how it has dealt with the serious recommendations of this committee.

[308] **David Melding:** I note that the guidance for temporary appointments is still a slippery issue. Perhaps you could tell us when you hope to nail that one down.

[309] **Mr Colman:** We are in conversation with Ann Lloyd's department about that. It is a problem because, constitutionally, appointments are the responsibility of the relevant board, and experience has shown that not all boards are equally competent at making senior appointments. However, it is difficult to address guidance to people telling them that they are not competent, so I can understand why it might take time to get the guidance in the right form.

[310] **David Melding:** Thank you for that.

4.25 p.m.

Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio, Gwneud Defnydd Gwell o Lawdriniaethau Dydd y GIG yng Nghymru, a Chyngor gan Archwilydd Cyffredinol Cymru
The Welsh Assembly Government's Response to the Audit Committee Report on Making Better Use of NHS Day Surgery in Wales and Advice from the Auditor General for Wales

[311] **David Melding:** This item relates to papers 7 and 8, regarding WAG's response to the Audit Committee's report, 'Making better use of NHS day surgery in Wales'. That is not so problematic, by the looks of it.

[312] **Mr Colman:** It is completely straightforward. The response is satisfactory. We will, of course, monitor progress. This is a good example of an area where—not uniquely, but perhaps unusually—progress in implementing these recommendations will both reduce costs and increase quality, so it is really worth implementing them, and we will keep an eye on it.

[313] **David Melding:** Are there any comments? I see that you are happy with this.

4.26 p.m.

Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio, Mynediad y Cyhoedd i Gefn Gwlad, a Chyngor gan Archwilydd Cyffredinol Cymru
The Welsh Assembly Government's Response to the Audit Committee Report on Public Access to the Countryside and Advice from the Auditor General for Wales

[314] **David Melding:** Item 7 relates to papers 9 and 10, regarding WAG's response to our report, 'Public Access to the Countryside'.

[315] **Mr Colman:** This, too, is positive and no further action is required by this committee at the moment.

[316] **David Melding:** I see that there are no comments from Members.

4.26 p.m.

Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio, Y Strategaeth Genedlaethol ar Ddigartrefedd, a Chyngor gan Archwilydd Cyffredinol Cymru
The Welsh Assembly Government's Response to the Audit Committee Report on The National Homelessness Strategy and Advice from the Auditor General for Wales

[317] **David Melding:** Item 8 is WAG's response to our committee report on the national homelessness strategy. Timescales seem to be something of a problem, but perhaps you can elaborate on that, Jeremy.

[318] **Mr Colman:** I cannot elaborate a great deal on this, Chair. I know that saying at the end of these letters that we will monitor the situation may look like an empty formula, but it is not. We do monitor the situation, and we are absolutely interested in timescales.

[319] **David Melding:** That is what you will monitor. Are Members content? I see that you are.

4.27 p.m.

Adroddiad Blynyddol y Pwyllgor Archwilio 2006-07
Audit Committee Annual Report 2006-07

[320] **David Melding:** This is the previous Audit Committee's annual report for 2006-07. It has been presented, and we are required by Standing Orders to lay it. We have all had a chance to read it and I do not think that any comments have come back, so I assume that we are happy for that report to be laid. I see that we are.

4.27 p.m.

Cofnodion y Cyfarfod Blaenorol
Minutes of the Previous Meeting

[321] **David Melding:** Are we happy with that? I have not received any comments—

[322] **Lorraine Barrett:** I cannot remember what happened in July. [*Laughter.*]

[323] **David Melding:** Okay, so we are happy to give it oblivious ratification.

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

Cynnig Trefniadol
Procedural Motion

[324] **David Melding:** I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[325] I see that no Member opposes that, therefore we will move into private session.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 4.28 p.m.
The public part of the meeting ended at 4.28 p.m.