Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyllid
The Finance Committee

Dydd Mercher, 08 Hydref 2014
Wednesday, 08 October 2014

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Christine Chapman	Llafur Labour
Jocelyn Davies	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)

Mike Hedges	Llafur Labour
Alun Ffred Jones	Plaid Cymru The Party of Wales
Ann Jones	Llafur Labour
Julie Morgan	Llafur Labour
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

Helen Birtwhistle	Cyfarwyddwr, Conffederasiwn GIG Cymru Director, Welsh NHS Confederation
Adam Cairns	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Chief Executive, Cardiff and Vale University Local Health Board
Don Peebles	Pennaeth Sefydliad Siartredig Cyllid Cyhoeddus a Chyfrifyddiaeth (CIPFA) yr Alban a Chynghorydd Arbenigol i'r Pwyllgor Head of Chartered Institute of Public Finance and Accountancy Scotland and Expert Adviser to the Committee
Paul Roberts	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Chief Executive, Abertawe Bro Morgannwg University Local Health Board

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

Bethan Davies	Clerc Clerk
Martin Jennings	Y Gwasanaeth Ymchwil Research Service
Tanwen Summers	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 09:04.
The meeting began at 09:04.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Jocelyn Davies:** Welcome to this meeting of the Finance Committee. I have no apologies or substitutions today. Before we go to our first substantive item on the agenda, perhaps you would check your mobile devices, just to make sure that they are on 'silent'. We would be very grateful. We are not expecting a fire drill, so, if the alarm sounds, it may very well be a genuine emergency, so follow the directions of the ushers, please.

09:04

Cyllideb Ddrafft Llywodraeth Cymru ar gyfer 2015-16: Sesiwn Dystiolaeth 2
Welsh Government Draft Budget 2015-16: Evidence Session 2

[2] **Jocelyn Davies:** We now move to our first substantive item, which is our scrutiny of the Welsh Government draft budget for 2015-16. This is our second evidence session, and we are taking evidence from health organisations today. Before we go to the first questions, would you like to introduce yourselves for the record?

[3] **Ms Birtwhistle:** Yes, certainly, Chair. I am Helen Birtwhistle. I am the director of the Welsh NHS Confederation and we represent the seven health boards and three NHS trusts in Wales.

[4] **Mr Roberts:** I am Paul Roberts, the chief executive of Abertawe Bro Morgannwg University Local Health Board. I am here because I represent the chief executives on finance issues and to represent the NHS as a whole, rather than in my capacity as chief executive of that particular health board.

[5] **Jocelyn Davies:** Thank you for explaining that.

[6] **Mr Cairns:** Good morning. I am Adam Cairns. I am chief executive of Cardiff and Vale University Local Health Board, and I am here because I was invited to attend.

[7] **Jocelyn Davies:** Thank you. Would you all like to comment on how successful the implementation of the National Health Service Finance (Wales) Act 2014 has been in terms of achieving expected benefits from the three-year planning horizon? Perhaps you would like to comment on the robustness of the planning systems. Shall we start with you, Helen?

[8] **Ms Birtwhistle:** Yes, certainly, and I will probably ask my colleagues who are involved in the planning system to come in. Looking at it from an overarching perspective, as you know, the three-year planning cycle was something that we were very keen on and were requesting for a number of years. In the respect that it means that we do not have to simply look at year-in figures, that we are able to plan with greater perspective, that we are able to look at the bigger picture and that there is an opportunity to look not only at objectives within individual health boards and trusts, which have their own individual accountabilities, and that is very important, but at responsibilities for the health service as a whole. It is still something that is being worked through; there is a lot of work still going on with all the various organisations on planning. However, generally, we think that it is very helpful and that it sets us off in a much better direction for the longer term sustainability of the NHS in Wales.

[9] **Jocelyn Davies:** Okay. Paul, would you like to comment?

[10] **Mr Roberts:** Yes, briefly if I may. The first thing to say, just to echo what Helen said, is that we welcome it. It is much better for public services to be able to plan over a medium-term period rather than rely on annual planning. However, it is really early days, so commenting on something when we are just about halfway through the first financial year of operating this system—. I think that we will be able to judge the success of it in the coming years.

[11] I have a couple of comments on the practicalities. What it enables us to do within our health boards and trusts is to have a different mentality about how we plan. If you have a one-year financial planning settlement, you are only really able to say to staff, ‘Here’s the saving target this year and here’s the likely pressures that you are going to face’, and it is quite reactive. If you have a three-year settlement, you are able to say, ‘How do we want to reshape our services to meet demands and stick within the financial envelopes that are available in

three years?', and, 'What are the phases in the next three years where we can make the different milestones to achieve that?' I think that you are able to engender quite a different relationship with your front-line staff by planning in that way. So, I think that it has been a really good thing, but it is very early days for us as organisations learning to plan in that way.

[12] **Jocelyn Davies:** Adam, is your experience the same?

[13] **Mr Cairns:** Yes, I concur completely with what has been said.

[14] **Jocelyn Davies:** Obviously, this is the committee that dealt with that piece of legislation, so we are well versed in the arguments for it. I know that a number of Members want to come in on this. We will start with Ffred.

[15] **Alun Ffred Jones:** Rydych yn sôn am gynllunio—. A ydych yn clywed y cyfieithu?

Alun Ffred Jones: You talk about planning—. Can you hear the translation?

[16] **Jocelyn Davies:** Yes, the translation is fine. It should be on channel 1.

[17] **Alun Ffred Jones:** Rydych yn sôn am gynllunio dros dair blynedd, ac yn amlwg yn meddwl bod hynny yn rhoi cyfle i chi roi cynlluniau yn eu lle. Fodd bynnag, rydych chi eisoes wedi cael newid o fewn y flwyddyn hon o £200 miliwn. Ni fyddech yn cwyno am hynny. Sut mae hynny yn mynd i'ch helpu i gynllunio eich rhaglenni, gan ei fod yn newid eithaf sylweddol a hynny yn ddirybudd?

Alun Ffred Jones: You talk about three-year planning, and that you obviously believe that that gives you an opportunity to put plans in place. However, you have already had a change within this year of £200 million. You would not complain about that. How is that going to help you plan your programmes, given that it is quite a significant change that came without any warning?

[18] **Ms Birtwhistle:** If I may start on that, Chair, we welcome the moneys that were announced in the draft budget, of course. I think that it is important to point out that those moneys in a sense plug a gap that was identified in the Nuffield report that was commissioned and published earlier this year, and that it does allow again for services where there is increasing demand year on year, day on day, for different types of services and for us to do different things. So, it is welcome. I think that what it is very important to point out is that, while we do welcome the money, obviously, it is not a windfall and it does not mean that we can go back to the status quo and that we do not need to continue to make changes. What it does do, as I said, is help to plug a gap that has been identified, and build on that to make longer term, more radical changes that, again, as I said, will improve patient care and outcomes, and put the NHS on a longer term sustainable footing. That is my initial response to that.

[19] **Mr Roberts:** I think the other thing, talking about three-year planning, is that—. One of the things, certainly, that our health board did was to look at financial balance over three years. Of course, there is a structural problem, to some extent, in the way that Government has to plan its cash on the annual resource allocation basis, which makes it very difficult in reality for money to be planned over three years. So, for us to plan to get a bit of headroom to invest in change and in service quality over a period of three years, which is what we put into our three-year plan, would have been impossible to achieve unless we had had a budget settlement that really reflected the cost pressures that exist within the NHS. So, speaking from my perspective, but I think that it is probably a similar story for many colleagues across the health service, what the settlement does is better enable us to deliver the plans that we have already produced. As you know, only a certain number of organisations have three-year plans, but I think that that better enables us to implement the plans that we already have. So, if you

were to look at ours, you would see that it fits reasonably well with what we are proposing to do within our three-year plan.

[20] **Jocelyn Davies:** So, when were you—perhaps you could tell us, Adam—aware that there might be extra money coming this year?

[21] **Mr Cairns:** There was an indication two or three weeks ago that there might be. We had no idea at that stage what that meant. We were aware that there were discussions happening in the Cabinet about this situation, and, obviously, the budget does need to get laid. How we respond to that, I suppose, is what lies behind the question that has been asked. I think that the first thing to say is that the Nuffield report has been a very powerful piece of work, and what that report says is that if the NHS in Wales had followed the trends that had been there for many years before four or five years ago, the gap between what the population health needs are today and the level of funding would have been in the order of £1.3 billion. However, over the course of the last few years, what we have done is to take off that upward trajectory around £1.1 billion of cost. As I read it, as I interpret what has happened, the £200 million that has been made available to the NHS this year is really about acknowledging that, without that, standing still would not be possible. The difficult message for us—and I completely understand that this is a really difficult message—is if you stand back and look at what is happening to our population, it is ageing; in our case, in Cardiff and the Vale, it is growing very quickly in terms of numbers; many of our communities in Wales are living in very deprived circumstances. All of those things are driving demand for healthcare services. We are a service with huge—absolutely colossal—fixed costs. For instance, if you just think about your own circumstances, energy bills are going up. Our energy bill went up £200,000 a month between last year and this year.

09:15

[22] The relentless problem that we face is the curse of large numbers. So, 1% movement on £1 billion is a great deal of money. The difficulty is that those inflationary pressures, either because of demand or because of cost, are impacting on us exactly the same as everywhere else, but the percentage difference converts into huge sums of money. People account for most of our costs. So, it is very hard to influence demand. We are working on that, but it is very hard to influence that in the very short term. So, if we are going to respond, what needs to happen is that we have got to think through how we can get by with fewer people, how we can redesign what we do, and, as my colleagues have been saying, making some of those changes is profoundly complex. That is one of the ways in which a three-year settlement begins to help, because we can start to think about running the conversations we need to have with our public, organising the way that we work differently and then implementing those changes, some of which will be very difficult to do.

[23] **Jocelyn Davies:** Okay. Mike, did you want to come in on this point?

[24] **Mike Hedges:** I want to come in on two points, one of which came up from what you have just said and one previously. First, you talk about a three-year plan, and I am somebody who supports a three-year plan, but, for as long as I can remember—and if you can tell me I have got it wrong, please do—the last three months of the year have seen substantial reductions in expenditure across health boards in order for you to come in on budget. However, we have never seen the full-year effect of the last three months. Let us say that the saving in the last three months should be multiplied by four. If you are saving 1% in the last three months, you should get a 4% saving over the next year. We have never seen that. What we actually see in the first quarter is overspends. The second question—

[25] **Jocelyn Davies:** That was not actually a question. Just agree with him. I think it is a good point to make.

[26] **Mr Cairns:** May I come in?

[27] **Jocelyn Davies:** Yes, do that before Mike comes on to his next question.

[28] **Mr Cairns:** I just have a very brief comment on that. What Paul was saying earlier on is that the focus on a one-year settlement drives behaviour. It alters behaviour. What people do is look to the year-end, and the focus is very much on how we can make sure that, at the year-end, the amount of money we have spent equals the amount of money we have received or is less than the money we have received. What that breeds is a culture of non-recurring action. What a three-year settlement allows us to start to do is to think differently and, indeed, achieve recurring change over the longer term. The problem is often that the recurring changes take longer than one year to implement. That is one of the principal benefits of a three-year plan.

[29] **Mike Hedges:** You said about energy costs that they are fixed and that there is nothing you can do about them, which frightened me because I believe that there are things you can do about them. You can change to LEDs and cut down on those costs. You can use photovolanic cells or as we better know them—

[30] **Nick Ramsay:** Photovoltaic.

[31] **Mike Hedges:** Photovoltaic, thank you. You can use those. You can use a whole range of other things in order to cut costs. We discussed the invest-to-save fund yesterday. Money has been spent by some people to do these things. If I say to you that I do not think that enough is being done to try to drive down those fixed costs and if I say that you have no incentive to drive down those fixed costs because you know that, this time next year, the Government will give you an extra £200 million, what do you say to that?

[32] **Mr Cairns:** I would say that we have got LED bulbs virtually everywhere. We have got a building that is nearly 60 years old on the Heath site, for example. It was not built to today's standards. The engineering, ventilation, power and plant are all very, very old. We have windows that are not sealed and we have roofs that leak. There are substantial issues that we need to be on top of to, almost literally, keep the roof on, and we do not currently have the room for manoeuvre that would allow us to invest in substantial changes, which would drive down revenue costs but at a capital cost that we currently do not have the means to deploy.

[33] **Jocelyn Davies:** Paul, do you want to come in on this?

[34] **Mr Roberts:** I do, really. I will not echo what Adam said. I think that he has answered the direct point. However, I think that there is a myth to bust here, and I think that it is really important that we do that. It is a shame from my point of view that that myth is not properly busted or the message received within the Nuffield report. With regard to this process of getting £200 million at a particular point in the financial year and thinking that that is going to happen every year, look at the figures that the Nuffield independent analysts talk about with regard to what the NHS has saved and achieved in terms of efficiency over the past few years. It is better than any other part of the UK NHS. It has been really successful in doing that. What we are saying is that we are moving towards a system that has a better and more sustainable way of financial planning. That is a good thing, and we welcome that progress. However, I think that there are myths to bust about where the NHS gets to each year and what leads to that. I think if we develop a better system for medium-term planning and for financial planning, then that is all to the good. However, the Nuffield report is clear on some of these issues, and we must not keep preserving those myths.

[35] **Jocelyn Davies:** I will come back to you, Mike, but, Helen, you wanted to say

something.

[36] **Ms Birtwhistle:** I would absolutely concur with what my colleagues have said. I think that the myth busting is really important. I would just like to say: let us please not forget that, since 2010-11 to 2013-14, the NHS in Wales has cut costs by over £1 billion. That is a huge amount. It has brought savings of 4.5% on average every year. As Paul says, compared with other parts of the UK, that is a huge amount. That is without the three-year planning cycle and system. So, I would not like people to think that fixed costs are fixed costs and that no-one has done anything about them or is doing anything about them, because it is just the opposite. The key to what all our colleagues are doing throughout the NHS is to divert as much of that money into direct patient care as possible. However, we have too many buildings; we have said that. As Adam has pointed out, many of them are old and crumbling. The University Hospital of Wales is not the worst of those by any means, and part of what we need to do is to stop relying on some of these old crumbling buildings that are not fit for purpose, which would allow us to take money out and reinvest in new services that are not building-focused, but are service and individual patient focused.

[37] **Jocelyn Davies:** Mike, you wanted to come back.

[38] **Mike Hedges:** Please bust the myth, but can I confirm that you will not be asking for an extra £200 million next year? That will bust the myth

[39] **Mr Roberts:** Well, let me just come back on that—

[40] **Jocelyn Davies:** I think that Mike is making a fair point in that every year you are told to live within your means, and every year there appears to be more money that comes in that way. I can see the point that you are making, but—

[41] **Mr Roberts:** What I think we have in front of us now is some good evidence from some external people. In particular, about the NHS in Wales, we have the Nuffield report. However, you do not have to travel very far to look at some of the other evidence about the funding of healthcare, such as the Office for Budget Responsibility's fiscal sustainability reports, King's Fund reports, and all of that. They point out some relatively simple realities about the funding of health, and other services too, which is that, with an ageing population, the growth of disease burden, and with growing technology available for healthcare, funding for health services and for other things that address those issues, such as social care, pension funding, and other such things, needs to grow at a rate that is faster than of the rest of the public sector, and is at least keeping up with the size of the growth in the economy.

[42] In the settlement that we have had this year, based on the Nuffield report, we have seen some recognition of that. However, we have to operate within the realities of the financial service and operational pressures that the health services face. We think that it is right that due note is taken of the external experts. So, it is not us for pleading for cash—they point out the economic realities of healthcare. That is not just about this year; it is going forward, too.

[43] **Jocelyn Davies:** Peter, did you want to come in on this?

[44] **Peter Black:** We have talked a lot about the revenue settlement and you have quite rightly identified issues in terms of the estate that the NHS manages. We have an annual report on that, I think, which indicates that the estate is full of hazards and dangers, not just to staff but also to patients, and that there is a need to invest in it. Although you have had an extra £200 million plus in-year and will also get it next year, there is actually a cut to the capital money that is being made available to the NHS. So, to what extent are you planning your capital investment and the business cases that you are putting forward to try to deal with

some of the revenue pressures in terms of making the estate fit for purpose, but also producing revenue savings as a result, and to what extent is the Welsh Government providing the necessary resources to do that?

[45] **Jocelyn Davies:** Who wants to start us off? Adam.

[46] **Mr Cairns:** We would not start from here. I think that is the first thing to say. It is really important because I think that, in most organisations, you would look at capital under three headings, basically. One would be estate. Another would be capital equipment, so x-ray machines, CT scanners, MRI scanners and that sort of thing—

[47] **Peter Black:** Which you can also lease, of course.

[48] **Mr Cairns:** You can lease, but that is a revenue cost. And then, we have IT. So, one of the big challenges that we have got is that it would be possible to lower our revenue costs by deploying capital, but the capital that is required to deliver that is not currently available. So, one of the questions that we are currently investigating is: are there alternative sources of capital? Are there other ways in which we could engineer that? We have mentioned one. We have recently done a deal with Toshiba, and Toshiba now supplies us with ultrasound equipment at our organisation. We pay it a monthly fee and it guarantees to give us up-time consistently, to update the software and to replenish the hardware, but clearly that is at a revenue cost that we then have to find by shedding staff and redesigning what we do. So, I think that, certainly for us, there is a very substantial pressure on capital, and most of our attention is spent, with the discretionary capital that we have, on, put bluntly, keeping the show on the road and not changing the dynamics of our system, unfortunately. That is simply a function of how much capital there is to deploy.

[49] **Peter Black:** There is £235 million available in capital next year. What sort of capital would you need, on an annual basis, to produce the transformative effect that you actually want?

[50] **Mr Cairns:** We have two sources of capital: the discretionary capital that each health board is given, which is a relatively small number, and then there is the block capital that we are able to submit business cases to, but that has to be spread right across Wales and, in every single part of Wales, I am sure that there are all sorts of important and necessary things that need to be done. Ideally, we would be funding our capital at the level of our depreciation, but we do not do that currently, and that is simply a function of the fact that there is not sufficient capital to resource that.

[51] **Mr Roberts:** I think that it is very hard to put a figure on it, because I think that it is a bit more complicated. I think that Adam has referred to some of this already. If you are asking me whether I would rather have a big trade-off between revenue and capital, with the staff we need to employ and the services under pressure, of course, my answer to that would be that we would not. However, what some of the alternative ways of funding capital development allow you to do is plan the revenue impacts over a much longer period of time. We have to make planning assumptions about what is going to happen to NHS funding, based on some of the sources of advice to Government at UK level and at Welsh Government level that I have mentioned already. In some cases, it is better to turn equipment investment, for instance, or even buildings—particularly looking at the renewal of the primary care estate, which is a good example—with revenue funding over some years, without falling into the trap that has happened particularly in England around some of the PFI debts.

[52] **Peter Black:** I have seen, for example, in Morriston Hospital, the transformative effect of that investment. Presumably, that is going to produce quite large revenue savings in terms of the management of that estate.

[53] **Mr Roberts:** Yes, that is correct.

[54] **Peter Black:** Should the NHS in Wales not be pulling together a capital plan to present to the Welsh Government and saying, 'This is what we need to get our revenue costs down and to transform our estate, and now that you have borrowing powers, maybe you should use them to help us to do that'?

[55] **Jocelyn Davies:** You need not answer that. Can I remind Members that another two Members want to come in on this question, and we are still on question 1? [*Laughter.*] We have already spent 25 minutes on this. So, Ffred is next and then Nick, and then we are going to have to move on to the next lot of questions.

[56] **Alun Ffred Jones:** Following on from what Peter said, it would seem that a costed capital plan, in order to drive down costs, would be—and you probably have one—useful to see what the size of that is, so that we can compare it with some other commitments that have been made. To be fair, hospitals have been thrown up over the past 10 years all over the place, so it would seem to me that a huge investment has been made. Are you suggesting that those have not been in the right places?

09:30

[57] **Mr Cairns:** No, I am sure that that is not true. I can only reflect on our own situation, so Paul might want to cover and discuss the other points. From our perspective, the challenge that we face is that the estate that we currently deploy is not actually designed to meet the needs of the patients whom we are now looking after. So, the average age of a patient who is admitted to our hospitals now is 84. Thirty or 35% of those patients have some form of cognitive impairment. We lack single rooms, we lack effective sanitary facilities in some areas, and we do not have all of the technology that we would like, such as hoists and other kinds of equipment.

[58] We also have substantial pressures on space, which, quite often, as you will know if you have ever been to a hospital, we have. I suppose what I am trying to get at is that, just in order to keep what we already have going, there is a huge cost. That is before you start to redesign what is there. We are not complaining about this, and we absolutely understand the world that we are in, but because of the shortage of capital in the UK, we have to focus on simply keeping things going, not within the discretionary money that we have, investing to reconfigure in the medium term. There are cases where we can do that and, clearly, we will be making as many submissions as we can to the Government to help us to do that, but the jam has to be spread around Wales, and decisions and choices have to be made.

[59] **Jocelyn Davies:** Okay. Nick, did you want to come in?

[60] **Nick Ramsay:** I was going to ask about examples of how the capital spend can reduce the revenue, but I think that Adam Cairns has just given a good example of that with the age profile.

[61] **Jocelyn Davies:** Okay. I think that we will move on. Julie, shall we come to your questions?

[62] **Julie Morgan:** Yes. This is more specific. I want to ask whether you are aware of any uncosted commitments in your forward plans.

[63] **Mr Roberts:** In terms of Government commitments or—?

[64] **Julie Morgan:** In your plans. In what you are planning to do, is there anything that is uncosted?

[65] **Mr Roberts:** I suppose what I alluded to earlier. I will take our plan as an example, because, as I say, I am here representing the wider NHS. What we did was we took the proposition literally about three-year planning and looked at our financial planning over a three-year period. In effect, we have put into our plan upfront investment in change, in improved efficiency, and in transforming some of our models of care, particularly between acute and community services. I think, until the announcements made last week, we were very nervous about whether those commitments could be followed. However, broadly speaking, the announcements last year, in terms of the first year of our three-year plan, help us to achieve that.

[66] If I were to express a concern—and I have touched on this already, really—it would be that the funding coming into the NHS is about existing service and population and chronic disease pressures. I think that there is a concern, particularly with headline figures that get covered a lot in the media, that people think that this is new money for new investment in new services. For us, what we are trying to do is use that money to change how we operate services. Certainly, from what has been announced so far, that accords reasonably with our plan. However, we all know that the health service right across Wales faces considerable cost pressures. We still have an unanswered question about what is happening with pay, as an intensive employer within Wales. The answers that come out eventually on pay, not just this year, but in future years as well will have a massive impact, and whether those are funded commitments, we will have to see.

[67] **Julie Morgan:** So, there are unknowns.

[68] **Mr Roberts:** Adam may wish to comment from his perspective on that.

[69] **Jocelyn Davies:** Do you have any commitments that are uncosted in your plans, Adam?

[70] **Mr Cairns:** I will comment on last year, because this is a case study, really. Last year, we looked at the amount of resources that we had and then we looked at the costs that we knew that we were going to incur. Those costs are fuelled by a population in Cardiff that is growing twice as fast as anywhere else. The birth rate is three times the rate anywhere else in Wales. We also have a very deprived community, with 130,000 or 140,000 people living in the most deprived communities in Wales. So, we knew that the demand pressures were foreseeable, predictable. When we looked at that we set a target for ourselves to take out what we believed was the absolute maximum that was possible within one year. That was not just our opinion, as we had external help to verify that. It was a very significant challenge. We managed to do that. So, last year, we took out £50 million of real, cashable costs. This year, because of all of those demand pressures, the size of our challenge has grown. So, this year it is not 5%, it is 6%. So, we have set a plan to take out a further 6% of our costs to meet those demand pressures. I have to say that I have never ever worked in a healthcare system that has achieved that level of cost reduction. We have set our stall out to do it. We are determined to do that, but the extent to which that is in the end possible will be seen at the year end. We are currently behind. Looking at this year, our plan expected us to have taken £13 million of cost out by now—and, Mike, your question about the recurring end of this is really important. Currently, we are about £6 million adrift, and that is because a number of things have changed.

[71] I will give you an example. We would ordinarily expect to treat a child with a particular form of disease or illness that needs treating maybe twice a year, and that cost would be £350,000 because of the drugs and everything else. So, we set a plan for £700,000

of cost for those two individual children. On average, that is what it has been for years. This year, we have had seven of them, which we were not expecting, but that is just a cost. So, we have had a number of those factors hitting our position this year. Some of the changes that we needed to make have got tangled up with the community health council, understandably. I am not complaining about that, but it has taken far, far longer than we had assumed that it would to make some of the changes that we are making this year. So, I would say that the commitments that we have made in terms of provision can happen only if we are successful in backing that by taking 6% of our costs out. One of the dilemmas for health is that, unlike a library, which, if you close, people just do not borrow books, in healthcare, if you stop doing something, that demand simply does not go away, but simply appears somewhere else. So, we have to meet all those demand pressures. That is inevitable. It is a really formidable task that we have set ourselves. I would say that we do not know yet how this allocation is going to be distributed. We really have no intelligence about that.

[72] **Jocelyn Davies:** It is the Townsend formula. The Minister told us last week.

[73] **Mr Cairns:** All right. We would very much hope that the way in which it is allocated reflects the demands faced by health boards. We would expect that to be a rational outcome, but we do not yet know. I do think that the challenges faced by health boards across Wales are all very different. As you no doubt will hear, everyone is special and everyone has their own issues, but they are different. I do think that there needs to be some basis on which all the money gets allocated ultimately and, indeed, the marginal increases that we are seeing this year.

[74] **Julie Morgan:** Adam, you have mentioned several times today the increasing population in Cardiff and deprivation. Obviously there is deprivation in many parts of Wales, but I accept that the population is rising fairly dramatically in Cardiff, compared with the rest of Wales. In the discussions about your budget, have you been able to put over those points to the Welsh Government?

[75] **Mr Cairns:** I have been making that case as clearly and as loudly as I can, not just on our own but together with Cardiff Council, which is also experiencing the same. It is a success story, is it not? Cardiff is booming. It is an economic success story and, as a result, we have companies headquartering there, we have people moving into the city, and we have a very vibrant and successful student population, with 66,000 students turning up in October to be educated in Cardiff. So, it is a success story. The issue for us is that that then presents us—of course it presents us—with fresh demand, demand that was not there in previous years. And it is growing all the time.

[76] **Julie Morgan:** Do you feel that you have been able to put across that point? For example, you had the deficit of £19 million last year. In the discussions about additional funding, have you had the opportunity to put that case?

[77] **Mr Cairns:** I have, and, as I say, we do not yet know what the outcome of that will be. That is not for us to decide, unfortunately.

[78] **Jocelyn Davies:** Helen, did you want to come in on this?

[79] **Ms Birtwhistle:** Yes briefly, if I may, and just as a top line. I think that what both Paul and Adam have described are the realities of planning, costing, making assumptions and looking forward. Going back to the first question about the three-year plan, that helps enormously; there is no question about that. Adam has described a particular situation in Cardiff, which many of us are aware of. You are right that it is to do with a Cardiff success story. Other parts of Wales have different changing demands and pressures. I think that what I would just like to point out about the planning process and making assumptions and looking

forward is that there is a difference between costing and contingency and building in assumptions, and then there are some, as Adam has very eloquently pointed out, complete unknowns that actually can throw planning and the budget. We all have to be aware of that. It can have quite a dramatic effect. Also, it can be an effect that is quite a high-profile effect, when actually it skews something and gives sometimes, I think, a false impression of the intense and rigorous planning this is going on behind the scenes.

[80] **Jocelyn Davies:** Julie, shall we come back to your questions?

[81] **Julie Morgan:** I was just going to say that, obviously, taking £50 million out of your budget was quite an achievement. I really find it hard to imagine how you managed to do that and keep up the service. Could you just tell us how you did that? I think that Paul wants to say something then.

[82] **Mr Cairns:** The approach we took was to look at how we compared with other healthcare systems around the UK. We spent quite a bit of time trying to understand where we were different, and then we tried to work out why we were different, and then we tried to learn from those places that were doing things more successfully and then we followed their lead.

[83] Last year, one of our big gains came about because we knew that people were staying in hospital longer than they wanted to or needed to. So, we speeded up many of our processes inside the hospital setting and brought down the average length of stay by two days within a year, which is good. What that allowed us to do was get by with fewer beds open, so that we were able to manage, if you like, with a smaller footprint in that sense. We also looked at the number of procedures that we were doing as day cases as opposed to people being in-patients. We looked at how often we were bringing patients in before the day of their surgery so that we could improve that experience for patients. We looked at how we could sustain and help people to stay at home, even though they were ill, by offering them support, which is a better way of doing it. It also costs us less.

[84] We also spent a lot of our time last year looking at areas within the work we do that were not designed to reliably always give the very optimal result. We modified dozens and dozens of areas of practice that we were deploying, all of which prevented mistakes, avoided having to do things more than once, and made sure that we were requesting only the tests that were needed and not more than we needed and so on and so on. In all of those ways and in a number of others too, we were able to bring down our costs, partly by lowering our head count. At the end of last year, we had 330 fewer people working in the organisation than at the start of the year. I do not take any pride in that, but it is a necessary component of bringing down costs when you employ so many people.

[85] **Julie Morgan:** Thank you for that.

[86] **Jocelyn Davies:** So, by reducing the number of days that somebody is in hospital, instead of treating more people, you lost staff.

[87] **Mr Cairns:** No. In fact, we treated more people through a smaller number of beds. If you just imagine being a patient who has been admitted, you do not want to be there any longer than you absolutely have to be. There were delays in getting all of the assessments done, the treatments implemented and then in planning people's return home. So, we have tried, as far as we can, to speed that up—

09:45

[88] **Jocelyn Davies:** So, it is looking right across the piece and saying to somebody,

‘Well, instead of coming in the day before your operation, come in on the morning of your operation, but don’t have anything to drink or eat before you come,’ rather than having somebody the night before. It is that sort of thing, right across the piece.

[89] **Mr Roberts:** Another example might be: instead of investing in another ward to deal with your pressures, it is just making sure that you have all the right diagnostics and therapy services there, on a seven-day basis, including during the weekends, and having those proper conversations with social care so that you are able to keep active treatment for patients right across the seven-day week. It is those sorts of processes.

[90] **Mr Cairns:** If I may, I will just add to that. To answer Julie’s question, that is what we did last year. You get to the point when there are diminishing returns, however, because, sooner or later, you are benchmarking with everybody else. You then start to go into much more difficult territory, which is radically changing what we do, and that is very difficult to do. About 50% of what we are trying to do this year is in that kind of territory. It is much harder to do.

[91] **Jocelyn Davies:** Okay, Chris, you wanted to come in on this point.

[92] **Christine Chapman:** May I just pursue Adam’s point? Obviously, there is a squeeze on staff. Could you identify any hidden costs to that? You have talked about looking after patients at home. Who is picking up the costs of that? Is that primary care? What about the declining number of staff? How is that being managed? Is there any cost to the staff in terms of added sickness levels because of too much work or stress? What is actually happening there?

[93] **Mr Cairns:** With this business about people being cared for at home, what I am really getting at is this: imagine that you have a very bad chest that you have had for many years, the not untypical way in which your year would work is that you might find that you got an infection two or three times a year, and, sometimes, those would be really serious and you would have to be admitted to hospital. Would it not be better if we could keep closer to you, see that you were starting to become unwell and treat you before that event occurred, so that you did not have to be admitted to hospital and you stayed at a better level of health? That is the kind of thing that I am talking about. So, it is not letting it all happen, booting you out quickly and hoping for the best; it is really about saying, ‘There may be a better way that we could look after people with some of these long-term conditions, and it would be better for everyone if we were able to work out how to do that more successfully’. It is things like that that I am talking about.

[94] In terms of staff, there is absolutely no question that our staff are feeling the pressure. I can see the population of patients who are being admitted to hospital changing before our eyes. The population is getting older, it is getting frailer, it is certainly becoming more confused and disorientated, and, unfortunately, many of our population are also acquiring lots of complicated diseases that are a function of growing older. In addition to that, we have a population of younger people who are abusing their bodies. So, we have 20-year-old women appearing in our gastroenterology clinic with cirrhosis to the liver. We are all—I certainly am—getting a little bit heavier. We are not leading healthy lives, and part of the challenge that we have got, also as a health board, is to look at those drivers. I think that we are going to have to be much clearer with the public about what we can do, what we cannot do and what their responsibilities are as citizens to manage their own health. I think that that is also part of what we have to do.

[95] **Jocelyn Davies:** Julie, did you have more questions?

[96] **Julie Morgan:** I think that that has covered it.

[97] **Jocelyn Davies:** Nick, shall we move on to your question?

[98] **Nick Ramsay:** Yes. Good morning. What additional outcomes are you planning to deliver following the additional funding linked to the Francis review, announced as part of last year's Welsh budget? Who is best to answer that? Is it Paul Roberts?

[99] **Mr Roberts:** I am happy to do that. I think there is a range of things that we have learned from reading the Francis report and, more locally, 'Trusted to Care', the Andrews report, which was looking at services in my particular health board as well. Clearly, we have the commitment from the chief nursing officer over staffing levels on wards. Certainly, in my health board—I am absolutely sure that this is the case in a number of health boards and, I am sure, all the health boards around the NHS as well—we absolutely had to make sure that our staffing levels were appropriate and met that guidance. That has been a really important part of the Francis report standards as well. It is not only about that, as it has also been about investing in things like multidisciplinary teams, because one of the lessons that comes through from the Francis report is not just about nursing and nursing staffing levels; it is making sure that, in each of your care teams, you have appropriate multidisciplinary teams working together that are appropriately resourced, too. So, those would be things like therapists and making sure that your medics are allocated towards a part of a multidisciplinary team.

[100] The other thing is that we have made direct investments in this in the last couple of years, and, in a sense, it relates to one or two of the points that Adam was making earlier about our estate. We have had to make investments in things like cleaning and making sure that we are better able to meet our environmental standards and our nutritional standards as well. These are all messages that come out of that report, and I think that our fundamental duty is to make sure that when we have patients in our care, in in-patient environments in particular—and there are all the different ways in which we need to change our services to make sure that that does not happen unnecessarily—that they can be cared for safely, with dignity and respect. So, those are some of the things that we are having to invest in, and I am sure that that is the pattern right across the NHS across the UK, but in Wales as well.

[101] **Nick Ramsay:** You mentioned the estate, and you are right; I asked about that earlier. In terms of the estate, in my neck of the woods, in south-east Wales, we have Gwent Clinical Futures, which I know has been slowed up somewhat, but is still very much the model that they want to pursue. Is there merit in that sort of model in any other parts of Wales? I do not think that it is being pursued in quite the same way elsewhere—I mean, with the separation of the intensive care element from the general hospital element.

[102] **Mr Roberts:** I am not familiar with the detail of the clinical futures model, I have to say, but if I talk about our case, then I suspect that what we are doing is not dissimilar to others. We have been running a programme called 'Changing for the Better'. What that is acknowledging—and, again, I think that this is something that we have been doing a lot in terms of the public debate about it—is that the days of the one-size-fits-all district general hospital are behind us, and that what we have are networks of services, including hospital services, and those hospitals have different functions within those networks. So, for us, we have an intense concentration on acute and intensive care services in Morriston Hospital, and that will increase over the coming years. It does not serve only the western part of our patch in ABMU; it also serves parts of Hywel Dda. We are having to make sure that we are focusing more cost effectively, but the evidence would suggest having, for better clinical outcomes, some of those services in fewer hospitals. That does not mean that there is not a really important role for some of the other hospitals, such as, in our case, Neath Port Talbot Hospital, Princess of Wales Hospital, Singleton Hospital, et cetera. Whereas that might not be precisely what is within the Aneurin Bevan model, I think that there are similar principles at

play.

[103] **Nick Ramsay:** Yes, in terms of focusing certain elements in particular hospitals, I think that that is the same. Thank you.

[104] **Jocelyn Davies:** Helen, did you want to add something to that?

[105] **Ms Birtwhistle:** Yes. I would just like to emphasise that there are specific models in different health board areas, but I think that what has moved on from Gwent Clinical Futures, 'Changing for the Better' and those in other parts of Wales, is a much more collaborative approach across health boards. The idea of centralising some very specialist services, concentrating and focusing resources, is something that, as a Finance Committee, I know that you are well aware of, as you are aware of the financial and resource benefits of doing that, not spreading resources too thinly, and making sure that when people do not need to be in hospital that there are proper facilities at home. If I may, it goes back to Christine Chapman's question and looking at the whole primary care support. One of the things that we are trying to do as part of the forward look for the NHS in Wales is to look at a new way of doing public services. Given the nature of the NHS—the fact that it is secondary care and the big hospitals that tend to suck up the money—that is where, if we are not careful, we all focus our attention. However, part of the whole resource allocation process, and the way that the NHS is working through the three-year planning system, is to look at a more integrated model with other parts of the public service as well.

[106] **Jocelyn Davies:** You say that you are looking at it with other parts of public service, so the cuts to local government must be of deep concern to you, if it is not going to be able to play its part in assisting you.

[107] **Ms Birtwhistle:** One of the things that we have been very clear about is our commitment to work with local government and with social care. I do not think that it is ever helpful—it is certainly not happening here, I know—to get into arguments about where the money goes, because the money has to go somewhere. Once it is spent, it is spent, and it is our responsibility to make sure that it is spent in the best way possible. We know that local government has a particular challenge—I know that announcements are being made today about local government funding and allocations. We recognise that there are services across the whole gamut of public service that have an impact on health. Health is not a standalone issue—

[108] **Jocelyn Davies:** That was my point, really.

[109] **Ms Birtwhistle:** It is true that there are relationships between services. It is incumbent on us to do the best that we can with the resources that we have, in conjunction with our colleagues in local government and social services.

[110] **Mr Roberts:** To echo that—

[111] **Jocelyn Davies:** I will come to you now. I note that Adam mentioned earlier keeping people well at home, and I would imagine that a range of agencies would be expected to play a part in that preventative spend. [*Interruption.*] Do not interrupt the Chair; I can see that all three of you are very eager to come in on this.

[112] **Mr Roberts:** We are passionate about these issues; that is why.

[113] **Jocelyn Davies:** You will have your chance. We have listened to you very carefully and we will listen to you. However, there must be concerns for you if some of those partners that you rely on to allow you to provide preventative care find themselves unable to continue

to do that. Adam, go on, and then I will come to Paul.

[114] **Mr Cairns:** I apologise. They are our partners; that is the bottom line. Locally, we understand the world that they are in. Let me give you a very quick case study, because I think that there are things—

[115] **Jocelyn Davies:** You are going to repeat all of your case studies; you know that, do you not? [*Laughter.*]

[116] **Mr Cairns:** Here is an example. Imagine that there is an individual who has many, many problems, such as arthritis, a bit of confusion, a heart problem and maybe a bit of diabetes. They are getting by at home and then they have a chest infection. Typically, what would happen is that that individual would get sent to the accident and emergency department. We do not know what yesterday looked like. All we can see is a very frail person with lots of things going on, so we begin to treat all of those things. It may take us some time to get to the bottom of all of those things. In the meantime, that individual is kept tucked up in bed, and what happens to older people is that they decompensate, as we call it—they lose their remaining capabilities very, very quickly. So, after about two weeks, we will probably find that it is very difficult to return that individual to their home. Who picks up the tab for that? Social services will, inevitably. So, would it not be better if we worked in partnership with social care so that we could avoid that cascade of events from occurring, and that we are able, together, to support that individual to return home and then reinstate themselves to the position that they were the day before? That is where we have got to get to, and that is the kind of deep collaboration that we are working on together in Cardiff and the Vale in our patch.

[117] **Jocelyn Davies:** I will come to you, Paul; you are interrupting Adam now. [*Laughter.*] I know that you are very eager—I will come to you—and I know that Mike Hedges wants to come in. Then we are going to have to move on.

[118] **Mr Roberts:** I guess that I wanted to give some reassurance, but let us not pretend—yes, we are concerned. As Adam has already said, local authority colleagues are our partners. I spend a great deal of time with local authority colleagues. We plan together, we work together, we develop services together, and, of course, we are very concerned about the impact on local authorities.

10:00

[119] I suppose that my assurance is that, in our regional collaborations, we are working really closely together, and my example is almost putting into a practical case what Adam has just talked about. Through the intermediate care fund, we have agreed with four authorities—ourselves and three local authorities—an investment of over £7 million in intermediate care. We have done a very careful business case on that, and what the business case demonstrates is that the financial benefits of working in that way accrue firstly in local authorities and accrue to health services further down the track, too. However, that intermediate care investment is to achieve precisely some of the benefits for individual patients that Adam has described. We got that through and we are getting that service set up right now, but we are working on a number of other programmes that are exactly like that. Local authorities, together with ourselves, see that as a way of working within the resource allocations that we have; that is the only way that we can do it.

[120] **Jocelyn Davies:** Mike, you wanted to come in on this.

[121] **Mike Hedges:** You have talked about social services a lot. Would you agree that it is not just about social services?

[122] **Mr Roberts:** Correct.

[123] **Mike Hedges:** The elderly ladies living fairly close to me who go, in fairly large numbers, swimming twice a week at a leisure centre are probably doing as much to improve their health as social services are doing for them. If they lose that leisure centre and do not engage in swimming, they will become your patients very quickly.

[124] **Jocelyn Davies:** Yes, before you answer that one, Nick also wanted to come in on this point.

[125] **Nick Ramsay:** Yes, I have another plug for Gwent Clinical Futures. It is well worth looking at that model and whether it could be enhanced across Wales, because Aneurin Bevan Local Health Board has managed to sidestep neatly a lot of the concerns in other parts of Wales about hospital downgrading and focusing of services. It has done it in quite a clever way, so I just think that it is well worth looking at where it has got it right in terms of perception and how you might roll that out elsewhere.

[126] **Jocelyn Davies:** We will just leave those comments on the record; there is no need to address them. We are going to move on to a real question now from Peter Black.

[127] **Peter Black:** No pressure. [*Laughter*.] Adam has already outlined some of the issues in terms of the changing nature of your patients and the impact that that has on your budgets. In terms of the three-year financial plans, what are the key cost drivers and the range of assumptions that you are using to predict those three-year plans?

[128] **Jocelyn Davies:** Paul, we are going to start with you—

[129] **Mr Roberts:** No, I am happy to—

[130] **Jocelyn Davies:** Okay. While you gather your thoughts on that, then. Adam, do you want to respond?

[131] **Mr Cairns:** On the key cost drivers, we have outlined them, Peter, as you indicated—a number of them. However, there are some that we have not talked about. So, we have talked about the size of the population in both meanings of the word—how heavy we are and how many we are. We have also talked about age and population health, or the morbidity—the amount of disease that we can see in our population. Those are certainly big drivers, and so is the economy; in a recession, we know that mental health needs go up and they certainly have, so we know that that is a factor. We know that we play an important role in Wales in settling people from other countries who are asylum seekers and refugees, and that is certainly a significant pressure in Cardiff—75 asylum seekers a week are settling in Cardiff.

[132] The prison has changed its role very significantly from a lifer institution to a remand prison. Four hundred prisoners a month are going through that system. That is a big issue for us, because 80% of those prisoners have mental health needs—

[133] **Peter Black:** Or they have substance misuse issues.

[134] **Mr Cairns:** Indeed, there are a whole series of issues like that. On the way that city centres operate, we have a night-time economy in Cardiff—90,000 people are on the streets every Friday and Saturday night. Alcohol-related treatment and alcohol and drug abuse are significant issues. However, above and beyond all of those demographic forces, we also keep inventing things, unfortunately, so there will be some new medicines that will help people to

live better lives that people will expect us to provide for them. There will be new technologies that will allow us to do more. However, it may be that the ways in which those technologies are deployed are less harmful to patients, but actually cost more for us. A good example of that would be endoscopic surgery, where we have very high consumable costs when that happens. I think that the other thing is that we are not immune from all of the other pressures that everybody else experiences in day-to-day life, namely inflation. Inflation on things like drugs is much higher than general retail inflation, and we spend £127 million on drugs every year in our organisation; 5% on that is a lot of money. So, those are all important drivers.

[135] Finally, the last one, which I think is really important, is that, unlike other parts of the public sector, we have national terms and conditions for our employees—it is called 'Agenda for Change'—for the majority of our staff, and those staff are entitled to annual increases in their salaries up to a threshold within a band. That is an inflationary pressure—a pay pressure—that is built into our terms and conditions of employment in the NHS. If there are pay awards on top of that, that is a further element. So, those are some, but probably not all, of the cost drivers that we experience. No doubt there are others that I have not mentioned.

[136] **Jocelyn Davies:** Paul, did you have anything to add to that?

[137] **Mr Roberts:** I will not go through that list again. I am sorry; I am scrabbling, because I knew that I had written down a list of some of these things, because I was expecting the question. I think Adam has covered most of them. Julie Morgan asked us a question about this to some extent, which was about policy changes—Welsh Government policy and UK Government policy—and what implications they might have on future costs as well. Those include things such as the National Institute for Health and Care Excellence and decisions that it made, the Royal College recommendations, and all of those things that are about standards that have cost implications on us as well. One of the issues that we are looking at very carefully at the moment, which is to do with the rise of the demographic changes, is the rise in the cost of continuing healthcare and funded nursing care in care homes.

[138] In practical terms, the finance directors have a financial modelling group, so we do a lot of the work within individual health boards and trusts and then we bring that work together to look at what assumptions we are going to be making in our plans across NHS Wales. We feed our thinking into Welsh Government and, of course, Welsh Government will have its interpretation of whether we are over-egging the pudding or whether it thinks our assumptions are reasonable ones. However, we do feed in collectively our anticipation of what the cost pressures are likely to be in the future.

[139] **Peter Black:** Okay. May I focus on just one of those things, because there is a lot there? I think we will touch on some of it later, anyway. On new technologies, we hear a lot, for example, about the cancer drugs fund in England, which tends to fund new cancer drugs coming through. Is the NHS in Wales properly resourced to take on board those new technologies and to deal with those experimental drugs as they come through, to give people—often only one or two individuals in some cases—the help they need to cope with their chronic illnesses?

[140] **Mr Cairns:** I think we have a very good process in place in Wales, actually. I do think it works pretty well. We have well developed mechanisms for identifying patients who may benefit from either experimental or new treatments. In each health board, there is a committee led by doctors that will examine the evidence and ask whether it does what it purports to do, what the benefits are and what the harms are. Quite often with these things, it is not all a free hit, as there are often very significant harms that these new technologies or drugs produce. Then, we also look at whether the additional cost of taking that choice is warranted, given the balance of benefits and harms.

[141] Therefore, there is, I think, a very sophisticated process that we use. We use that process not just for drugs, but for unusual and rare procedures that some people may need or believe they need to have. I can remember a couple of very recent cases that we put through that process. In one case, we thought it was, on balance, the right thing to do and, in the other, we concluded that it was not. So, I think you can be assured that there is a very robust process that we use to evaluate all of those things very carefully.

[142] **Jocelyn Davies:** Is that process accessible to the patient?

[143] **Mr Cairns:** Yes. The patient—

[144] **Jocelyn Davies:** Are they helped to make that bid?

[145] **Mr Cairns:** The way it works is that a patient will meet their clinician, and many patients now come armed with the latest information from Google, not all of which is reliable, it has to be said. Nevertheless, they turn up with that information. Then, there is a conversation between the clinician and the patient about what the clinician feels is in the patient's best interests. Where we agree with the patient that there is the possibility of something novel or new that might benefit the patient, the clinician knows what to do; there is a mechanism that they can use that enables us to understand that they are now making a request for something novel, different or new. We can then evaluate that properly and we feed back to the clinician and to the patient so that everyone knows where we are.

[146] **Jocelyn Davies:** Peter, have you finished?

[147] **Peter Black:** I am fine.

[148] **Jocelyn Davies:** Do you want to come in on this, Ann?

[149] **Ann Jones:** Yes, because it is part of the cost pressures. It was just to turn to litigation. You touched upon Google and patients turning up, and were asking us whether we want to try to bust some myths. Is there a myth—or is it an urban myth—that GPs will refer to secondary care or district general hospitals, consultants or whomever, rather than attempt to deal with that for fear of litigation? I suppose that this is a question for the confederation. What is the current state of litigation across all of the trusts that you represent? How is the risk pool bearing up, and are you having to put more money into it?

[150] **Ms Birtwhistle:** I do not have details of the risk pool and the litigation—

[151] **Jocelyn Davies:** Could you get a note for us?

[152] **Ms Birtwhistle:** We can, for sure, get you a note. I do not have the detailed figures. What I think it is important to say in general—and it goes back to what Adam was just talking about with his case study, the drugs, and rare drugs—is that we do need to be very careful about looking at how we involve patients and individuals in very honest discussions about care and treatments. I think that where patients are involved—and we are seeing that more and more; as Adam said, people are much more informed as well, and quite rightly—their opinions are valued; they are a valued partner in this process. I think that we need to be aware of that and aware of their needs. I think that it is all about prudent healthcare. Actually, this does relate to the litigation issue as well and the way that GPs are part of the treatment process and the referral process for patients. I think that it is about making sure that all staff at all levels are empowered to have those conversations. The things that we hear are very much the very high-profile news stories, particularly around drugs funding, perhaps. We all have to be aware that there is a cost to absolutely everything that happens. I think, in the way that GPs deal with their patients, they have an enormously complex job and are making decisions all of

the time, and very sound and good decisions, in conjunction with patients. So, we will get the details, but I am not aware that that is an issue.

[153] **Mr Roberts:** Perhaps I could pick up on that first element of the question about GPs. I think that it is unfair to put that myth onto GPs. I think that it is better to look at it in this way: I think we probably have to do more to work between primary care and secondary care to make sure that pathways of care for patients are much more clearly established and are evidence-based. That is a good prudent healthcare principle, as Helen has alluded to. Some of that is about making access for GPs to secondary care opinion easier to get, and not necessarily through the traditional routes of referring a patient into an outpatient appointment, but telephone accessibility, or guidelines accessibility. We are working on all of those things, but I think that we can make those things better. I think that you can forgive a GP, where there is no clear pathway identified, or no easy way to access secondary care, for referring them through the normal route. I think that that is reasonable behaviour. So, we have to do it better.

[154] **Ann Jones:** On litigation when something goes wrong, so, if something goes wrong and a family feels aggrieved and they want to take action, and then, whoever it is—the health ombudsman or whoever—finds against the NHS, how does the risk pool work? Is there sufficient—? Are you having to put more into that risk pool?

[155] **Mr Roberts:** As I think that we said, we would need to provide the direct information on that, but the answer is 'yes'. It is an increasing area of expenditure. I think that there are a number of ways of trying to mitigate that increase, and—.

[156] **Jocelyn Davies:** If you could kind of get your answer to link even a tiny, weeny bit to the draft budget, I would be really delighted. [*Laughter*.]

[157] **Ms Birtwhistle:** We will do our very best.

[158] **Jocelyn Davies:** Obviously, there needs to be, when these cases are taken—. These are substantial costs that are rising all of the time, and that does have an impact on the money that is available within the service. Adam, you are going to rescue us all and bring us back to the draft budget.

10:15

[159] **Mr Cairns:** I do not know whether I can do that, but, of course, litigation is, if you like, driving forward, looking through the rear view mirror, is it not? It is about what has happened that has gone wrong that we now know is coming towards us. So, the question is: can we try to find a way, going forward, of ensuring that fewer of those things happen? One of the ways that we can do that is to talk to our patients early to say, 'Something's gone wrong. It shouldn't have happened. We're very sorry. This is what we're doing about it.' I think that this defensive culture, the mindset that you are quite right to point out, and that I am sure is around—. The more that we can do to treat people as grown-ups and explain to them what has happened, the better it will be and the less likely it will be that we will find those costs coming towards us in quite the same way.

[160] **Jocelyn Davies:** Adam, I would agree with you, because I am sure that all of us who have dealt with somebody who is considering taking a case know that what they want is to know that lessons are going to be learned. They pursue a case in order that lessons can be learned, because they have come up against a brick wall, so that it will be different for other people. Nick, did you want to come in on the draft budget?

[161] **Nick Ramsay:** Yes. The draft budget, Chair—[*Laughter.*] The draft budget, which

we are here to discuss, does not contain funding—I think that we are all well versed in this—for a stand-alone cancer drug treatment fund, as exists across the border. What you said about the discussion that goes on here between the patient and the clinicians about what their treatment might look like sounded great, but is it not the case—this might well be one of Ann's urban myths, in which case, feel free to bust it—that the procedures that we have, which you outlined, do not provide the same amount of treatment for those people as is happening across the border in England? I have probably not explained that very well, but, in other words, a cancer drugs treatment fund would allow—. It just happens. More drugs are accessed through that than is happening under the procedure here.

[162] **Mr Cairns:** I think that what lies beneath the question, really, is, 'What's the mechanism for accessing those drugs?', and we have a different mechanism. Our mechanism, I think, is a good one. I think that it bears scrutiny and is robust, and, if I were a patient looking to put some poisonous material into my mouth, I would quite like people to properly look at that and tell me, 'You may get an extra week or two weeks, but it'll be pretty miserable.' I do think that it has to be seen in that context. These are not miracle drugs that cure people more often than not. They are usually, if you are talking about drugs and cancer, about prolonging life. One of the really big and difficult questions is, 'What's the quality of that life, if you're spending three weeks with your head down the toilet? Is that really the right thing?' We have to look at that in the round, and our process, I have to say, I think is a good one. I think that this is one of the things that we do quite well.

[163] **Jocelyn Davies:** Okay. Ffred, shall we move on to your questions?

[164] **Alun Ffred Jones:** Iawn, diolch yn fawr. Rwy'n mynd i osgoi'r demtasiwn i nodi anawsterau sy'n wynebu ardaloedd a phobl sy'n byw mewn ardaloedd mwy gwledig gwasgaredig, gan mai Pwyllgor Cyllid Cynulliad Cenedlaethol Cymru ydy hwn ac nid Pwyllgor Cyllid Caerdydd—i gael hynny i mewn. Rwyf i eisiau edrych ar flaenoriaethau mewn dau gyd-destun, sef yr arian sydd wedi cael ei glustnodi ar gyfer eleni yn y gyllideb atodol drafft ac ar gyfer blwyddyn nesaf. Ers 2004, mae'r Llywodraeth wedi bod yn rhoi arian i'r byrddau iechyd er mwyn llenwi bylchau a llynedd roedd hwnnw'n £146 miliwn. Eleni, mae £200 miliwn wedi cael ei roi yn ystod y flwyddyn. Y cwestiwn sy'n codi ydy: a oes cynlluniau penodol ar gyfer y £200 miliwn? Hynny ydy, a oes yna drafodaeth wedi bod ynglŷn â thargedau neu rywbeth felly, neu a yw, gan ddefnyddio'ch geiriau chi, Helen Birtwhistle, yn '*plugging the gap*'?

Alun Ffred Jones: Fine, thank you very much. I am going to avoid the temptation to note the difficulties affecting areas and people living in more rural dispersed areas, as this is the Finance Committee of the National Assembly of Wales, not of Cardiff—to get that in. I want to look at the priorities in two contexts, namely the funding that has been allocated for this year in the draft supplementary budget and for next year. Since 2004, the Government has been providing money to the health boards to fill in gaps, and last year that was £146 million. This year, £200 million has been provided during the year. The question that arises is: are there specific plans for the £200 million? That is, has there been a discussion about targets or some such things, or is it, to use your words, Helen Birtwhistle, 'plugging the gap'?

[165] **Ms Birtwhistle:** Paul, do you want to answer that?

[166] **Mr Roberts:** I am happy to answer that. I feel that I have touched on these issues already, so I will try not to be too repetitive of what I have said already. I do not think that a system that is all about producing extra money in-years and a one-year financial planning system serve the NHS or the people who use it very well, so I appreciate that we are seeing a longer term approach to funding the NHS. I would just go back on this. On the £200 million that we are talking about now, go back and look at what the Nuffield report says. It is about

existing pressure in the service, existing needs for change, existing demographic pressure, chronic disease, et cetera. I am worried that people are under the impression that a £200 million addition to the budget is about new services. Now, in our case, and in most of our cases, we may have approached this in slightly different ways. Health boards and trusts will do that. We have produced a plan for three years. What the budget settlement that was announced last week enables us to do is to get on and implement that plan—broadly speaking, as we did not know exactly what was going to be in the budget settlement, but, broadly speaking, it helps us to do that. So, if you want to see in my health board what the plans are, take a look at our three-year plan. Broadly speaking, you will have it set out there. We will have to make adjustments based on the detail of the settlement, and I am sure that there is an equivalent case in most of the health boards and trusts.

[167] **Alun Ffred Jones:** A derbyn yr ateb hwnnw, cawn edrych ymlaen at y gyllideb ar gyfer y flwyddyn nesaf, lle mae'r Gweinidog yn sôn am ychwanegu at eich cyllideb chi. Mae'n dibynnu ar ba ffordd yr ydych yn edrych arno, ond mae'n sôn am gynnydd o 4.6%, os wyf yn cofio'n iawn, yn y gyllideb ar gyfer y flwyddyn nesaf. Nid wyf yn siŵr a yw hynny'n gywir mewn termau real, ond dyna'r hyn sydd yn y gyllideb. A yw'r arian ychwanegol hwnnw yn mynd i ganiatáu i chi wneud gwelliannau yn y gwasanaethau a'r newidiadau yr ydym wedi clywed y mae angen eu gwneud, neu a yw hwnnw hefyd, yn y bôn, ond yn llwyddo i gynnal pethau fel ag y maen nhw?

Alun Ffred Jones: Accepting that answer, let us look forward to next year's budget, in which the Minister is talking about an addition to your budget. It depends on how you look at it, but we are talking about an increase of 4.6%, if I remember correctly, in the budget for next year. I am not sure whether that is correct in real terms, but that it is down in the budget. Is that additional funding going to allow you to make improvements in the service and the changes that we have heard about that need to be made or is that also, essentially, only managing to sustain things and keep them as they are?

[168] **Ms Birtwhistle:** By sustaining and supporting existing services, and dealing with existing and increasing demand, it does allow headspace to begin to look at the changes that need to be made in the longer term. I think that I said right at the beginning that we really do want to dispel any idea that the money, although incredibly welcome, because I think that it is a recognition of the pressures that the NHS has been under and the work that it has done to mitigate this pressures—. It is not a windfall. However, what it does enable us to do is to, as I said, get on a more even keel and a more sustainable footing with all the pressures that Adam and Paul have talked about and, taking your point, looking right across Wales, because all the health boards are involved in these processes in huge detail. However, the fact is that the changes that need to be made—to shift services, to disinvest in some services and reinvest in others, to change mindsets and to work more closely in partnership with other parts of public service—have to continue apace. We cannot take our foot off the pedal, because, in the longer term, to make the NHS sustainable, we absolutely have to make radical and transformational changes, and we have to be allowed to do that.

[169] **Jocelyn Davies:** Paul, you have a quick point, and then, Adam, did you want to come in on this?

[170] **Mr Cairns:** Yes.

[171] **Mr Roberts:** Just picking up on the figures, let me say that my understanding of the budget settlement—you were mentioning the figures—and then my understanding about what that means is that, if you look at the revenue increase for the NHS, it will be £200 million in this year, and, on top of that, an additional £25 million next year. So, there is an increase in the revenue budget for the NHS of £225 million, plus some adjustments on the capital budget, too. However, let us stick with the revenue budget. The first thing to say, and I think that this

needs to be put on record on behalf of the NHS, is that we completely recognise the really difficult decisions that the Welsh Government has to make about how it prioritises spending. We have already had a discussion about local authorities and local government spending, so we very much know that the Welsh Government has made some really difficult decisions to put money into the health service, which all the evidence tells us that we need. However, I would echo Helen's point, which is, if you go back and look at the Nuffield report, it talks about a standstill position in healthcare—and that is not just healthcare in Wales, but healthcare across the developed world—of something like 3.5% a year just to keep your head above water, based on population pressures, technology changes, chronic disease growth and all the rest of it. So, this does not take the financial pressure off the NHS in future years. We have got a lot of work to do in terms of transformational change—some of the things that Adam has been talking about—to make sure that we are able to live within the amounts that we are allocated. So, I want to be really clear about that.

[172] **Jocelyn Davies:** Adam, do you have a comment?

[173] **Mr Cairns:** I do not want to anticipate further questions. If we are going to cover the question of approving three-year plans and so on, there are some things about that that I think are worth exploring. We will do that later perhaps.

[174] **Jocelyn Davies:** Okay. Ffred, do you have any more questions?

[175] **Alun Ffred Jones:** No.

[176] **Jocelyn Davies:** No. Chris, shall we come to your questions?

[177] **Christine Chapman:** Further to that point about the extra funding, I think that you are saying that, hopefully, there will be improvements. However, what sort of dialogue are you having with Welsh Government on the changes, so that there will not be any surprises for it at the end of the year? Is this dialogue about how this extra spending is being used ongoing?

[178] **Mr Roberts:** I know that I keep having to reiterate this, but I feel that, in some respects, because of the way that some of the questions are phrased, I need to do this: effectively, the hard-fought-for money that is being put into the NHS this year is essentially about meeting existing costs. So, I am being really quite direct about that. In meeting existing costs and funding the health service that we have, what the Government and the people and, I am sure, you expect to see is us improving our performance and the things that we are doing. So, we have delivery plans covering a range of conditions for patients right across Wales. We are struggling, as you know, in some places on some of the targets we have as the NHS as well. The deal has to be that we keep our efforts on trying to improve our performance as the NHS more generally. However, I do not think that anybody should see the money being put into the NHS is being about new investment in some of those things. It is about costs that we have within the system.

[179] **Jocelyn Davies:** I think that you have made that point.

[180] **Christine Chapman:** I want to move on. Helen made the point earlier that health is not just determined by hospitals but other services as well. I think that we touched on this, but I wonder whether you could elaborate. Obviously, there are going to be big changes in this draft budget for local authorities. Do you anticipate any problems with the preventative work that we have talked a lot about, bearing in mind that we hear the settlement this afternoon? What specifically do you think is going to happen on that as far as the preventative work that you are doing jointly goes?

[181] **Ms Birtwhistle:** My colleagues may have more detail from work on the ground. The

preventative agenda is enormously important. We put a lot of time and effort and significant financial investment into the preventative agenda and into helping people to live longer, healthier and more productive lives. However, we can only spend the money once, and that is where we are talking about priorities and having to make priorities and needing support to order our priorities and having support in making those priorities. So, when we talk about money spent in the health service, it is money that is being spent already on patients and on people and on the population. We know that, in the longer term, the prevention of ill health is key for us. For instance, last week, the NHS in Wales, the Welsh NHS Confederation, signed a memorandum of understanding with Sport Wales to try to embed that type of integration and joint working at all levels of our communities to create healthier communities. The confederation is working very closely with the Association of Directors of Social Services Cymru on a programme called Strengthening the Connections, which involves local government, third sector organisations and individuals. All the indications are that that is a very successful piece of work. It is looking at implementing the Social Services and Well-being (Wales) Act 2014 and a lot of it is to do with wellbeing and prevention. So, there is investment in prevention in all sorts of ways—

[182] **Jocelyn Davies:** I guess that what we are getting at is this: what are your concerns in relation to your partners being able to sustain the actions that they are taking that link into this? Do you have concerns in relation to that, when what we are hearing from others is that they will not be able to do that stuff anymore?

10:30

[183] **Ms Birtwhistle:** We share their concerns. We know the pressures that they are under as well, which is why we have committed, as far as we are able, to work in partnership with them to address those concerns, but—

[184] **Jocelyn Davies:** If they cannot do that, do you expect—because you have just said that it is preventative work—your costs to rise, as a result? You know, if my mother's handrail does not get fitted and she breaks her hip, she is coming to your hospital and you will have to cancel somebody else's operation, because she is in that bed. There is no saving.

[185] **Ann Jones:** She might be in longer, as well.

[186] **Jocelyn Davies:** Yes, and do you know what? We still have to fit the handrail—and that is if she gets back home.

[187] **Ms Birtwhistle:** That is absolutely recognised, but as we say, we cannot spend £1 more than once and it is about where it is spent.

[188] **Jocelyn Davies:** Adam, you wanted to come in.

[189] **Mr Cairns:** This is the world that we are moving into, is it not? When we talk, it is easy to say, 'the age of austerity', but actually, it is going to have to be really different. So, there are different kinds of prevention work that we do—some we do well; some we do not do at all well. So, the kinds of things that we tend to think about are smoking tobacco and those sorts of things. Possibly, we might need to be a bit more robust as healthcare providers about what we expect the citizen to do for themselves, maybe.

[190] However, last night, I was out meeting some residents who live near a hospital and we were talking about what it is like to be a citizen at the moment. That community meets regularly; they are all having coffee mornings and organising for themselves—. We need to think differently about what it means to provide healthcare. I think that it is often about treatment; we tend to think of it like that. I think that we have to progressively move more and

more into working with communities, alongside and inside communities, so that we are taking every opportunity that we can find, whether it is third sector, or people volunteering themselves. We need to amplify every single opportunity that we can find to encourage people to help them to make better choices.

[191] **Jocelyn Davies:** Chris, do you want to come in?

[192] **Christine Chapman:** Yes. I just want to come back on that. I will not relate the actual conversation, but do you think that there is still a lot of resistance, say, between local authorities and health boards to sharing services and budgets, because, obviously, everybody is under pressure? Do you think that everything is being done that is possible? As Helen said, we can only spend that money once, but the more you collaborate and really talk to each other about it, it should be a better outcome. Everything is difficult, but—

[193] **Mr Roberts:** It feels to me that, as in any environment, there is some natural resistance to change and fears about control over policy direction and who is in charge of this particular service and accountability and all of those sorts of things. All I can do is speak from my experience of working within the western bay programme, which is our regional collaborative. I think that we are all facing this reality that Adam has just been describing. We are accepting that we have to work together on these things in a far better way than we have done in the past. I think that we are agreeing to pool our authority and our autonomy to work on these things much more closely together.

[194] I am not saying that it is perfect, but I feel that there has been a sea change in that and, as Adam has touched on, a major element of that is the third sector. So, it covers a huge range of types of organisations, but community groups through to some of the national bodies have a huge amount to offer within that. So, I think it is local authorities, communities and health services.

[195] **Jocelyn Davies:** Adam, have you felt—

[196] **Christine Chapman:** Can I go back to—

[197] **Jocelyn Davies:** Just a minute. Adam, have you felt any resistance, or is your experience the same?

[198] **Mr Cairns:** I think that we have had a very similar experience. In fact, one of the things that we have tried to do is—. This is all about trust, actually and you have to build that up; you cannot acquire it, you have to build it up. So, we have taken care to spend time building that trust between us and then we have tried to work out how we would test whether or not that happens. For example, in the Vale, we now have a manager who is responsible for both the social care budget and the healthcare budget and they just decide and that is fine. That is great.

[199] **Jocelyn Davies:** That is a new development, is it, in very recent times?

[200] **Mr Cairns:** Yes. We have health and social care teams now. We have found accommodation between us to bring them all together into the same location, so they work together. There are things in the way, such as the IT, but they do work together. We have also started to try to develop, rather like Paul was saying—. If you want to be hard-headed about this, what is the business case here? There is one. Forget altruism and doing the right thing; there is actually a business case here as well, with which we can cement that trusting relationship.

[201] **Christine Chapman:** We talked about the third sector, but local authorities are

obviously very challenged at the moment. Do you think that there is more that local authorities could be doing? I refer to the relationships that you have with local authorities.

[202] **Ms Birtwhistle:** I think that there is always more. I think that the third sector is really important, and we have mentioned that. If I may just give a very brief case study: we organised an event recently that had people from all levels of the health service, social services, third sector and housing. We were looking at the future and pooling some ideas. After the question and answer session, someone came to me and said, 'Do you know, that was really refreshing to hear the answer to those questions from very senior people in health, social care and throughout public service'. The question was: if you were given money, or if you won the lottery now in health area X, what would you want to spend the money on? What this person commented to me was that, for the first time, from every sector, people did not say, 'Oh well, we would build a new something', or 'We would provide this service within our own patch'. The health person said, 'Do you know, I would build a new road to allow people to get to work from areas that are not terribly accessible, and that will improve health; it will improve the health of our communities and the health of our nation'. There were similar sorts of answers from the other sectors. So, I think that it is about trust, I think that it is about mindset, and I think that it is about looking beyond our own sectors. That is really difficult in a time of austerity, but I think that that is the only way that we are going to be able to sort this issue.

[203] **Christine Chapman:** I have a final question. Again, it is specifically on the draft budget. What do you think that the Welsh Government should be doing in its draft budget to make healthcare a lot more financially sustainable in the future?

[204] **Mr Roberts:** I am happy to have a go at that. I personally think that there are a number of elements of a sustainable financial system. The first, obviously, is how much cash is made available. I think that I have spoken to that quite a lot this morning; so, perhaps I will not go through that again. However, the Nuffield report gets it pretty well right in my view. Secondly—

[205] **Jocelyn Davies:** Paul, I have been counting: I think that that is about 15 times now that you have mentioned the Nuffield report. We get it. The Nuffield report is not a get-out-of-jail-free card.

[206] **Mr Roberts:** No, but what I am trying to suggest—if I can be quite direct about this—is that, in some of the questions that I have been asked I feel that perhaps not all of the messages in the Nuffield report are as widely understood as they could be. It is not only the Nuffield report. We can direct ourselves to a number of other similarly independent pieces of work done on healthcare generally, not necessarily just on Wales, that give very similar messages.

[207] In terms of describing a sustainable financial system, there is the actual amount of money, is there not? Secondly—and Adam touched on this earlier, I think, in answer to a question that he was asked—is that it is a matter of how it is allocated, and whether there is a rational, understood and transparent way of allocating money. Of course, if there is one, and the Townsend formula that you have described, Chair—

[208] **Jocelyn Davies:** I am just saying that that is what the Minister told us last week when we asked how this was going to be distributed.

[209] **Mr Roberts:** Okay. You also need to have a process in place that deals with the consequence of allocating money in that way, because it will have negative consequences for some and positive for others. You have to be explicit about that and understand how that is going to be dealt with. You also then need a financial planning regime that allows you to

make financial plans over the medium term, which has stretched targets in it and which takes into account Government policy objectives. I think that we have moved a good step in the way of that. I think that the last component that I would mention is that you need, particularly in the modern NHS, to take account of the fact that patients move around the system and that we have to have more sophisticated financial methodologies for dealing with that. So, whether that is between health boards—. Adam is a big net importer of patients coming in for specialist care in Cardiff. That needs to be dealt with properly, but we are also moving patients between the acute sector and primary care sectors as well, and we have to make sure that there is a good system for accounting for the financial implications of that. So, to create a financially sustainable system, I think that those are probably the key components that we need.

[210] **Jocelyn Davies:** Nick, you wanted to come in on this, did you not?

[211] **Nick Ramsay:** Yes, I had to come in on this and respond to Helen Birtwhistle's earlier comment. You mentioned that something like road building could be seen in the broader field as part of the NHS budget.

[212] **Jocelyn Davies:** We all winced a bit at that. [*Laughter*.]

[213] **Nick Ramsay:** I have heard of social services and local government spending being part of it, but I have never heard of road budgets being included. Do you not appreciate that, if you want to draw the definition that broadly—and I kind of get the thinking behind why some people might—you are going to get into the problem of it being almost impossible to quantify the benefits you are getting from that? You have also got to quantify, with a road, for instance, the effect of the particulates and the pollution on people who live near that road, as well as road accidents—

[214] **Jocelyn Davies:** Look. Do not even try to justify—

[215] **Ms Birtwhistle:** I wish I had not put my foot in it, but—

[216] **Nick Ramsay:** It was a comment that was made and I think that it has to be addressed.

[217] **Jocelyn Davies:** No, no. I think that, in fairness, it was an example of people thinking about how others influence what they do—

[218] **Ms Birtwhistle:** Yes, another thing that was said was: education, education, education. If that is any help—

[219] **Nick Ramsay:** Well, I can understand that more than the road example.

[220] **Jocelyn Davies:** But still, it was—

[221] **Ms Birtwhistle:** [*Inaudible.*]—if you come from a valley.

[222] **Jocelyn Davies:** Yes, okay. Mike, shall we go on to your questions?

[223] **Mike Hedges:** I have two questions. One thing that always worries me is that it is almost like 'For health, see hospitals'. That does concern me. The question I have is this: could more not be done following the renal example—and this question is aimed at Paul—with Morriston Hospital acting as a hub and a number of other hospitals acting as spokes? Could more not be done across areas like that in order to reduce costs and improve the service?

[224] **Mr Roberts:** I think that the simple answer is 'yes'. I think that making sure that you concentrate appropriate services in certain places but do not deal with patients who do not need those very specialist services in those places is cost-effective. In other words, it helps you to contain costs, but it is also effective because, generally speaking, there is good health evidence that you get better outcomes from doing it, as well.

[225] **Mike Hedges:** It has happened in renal services for well in excess of 10 years, probably 12 years. It has not expanded to very many other services during that time. It does go across board areas, and I think that that is a problem because the west Wales board area does not actually have a major acute hospital in it. It has lots of smaller hospitals. So, Morriston acts as the main hospital for an area that it is not actually in.

[226] **Mr Roberts:** Well, I—

[227] **Jocelyn Davies:** Do not answer. That was not a question.

[228] **Mike Hedges:** The question that I am getting to is: what happens after 2016? At the current rate of increasing health budgets, you get 100% of the Welsh budget. What happens then? You cannot keep more than 100% of it.

[229] **Jocelyn Davies:** If you say 'Nuffield', Paul, I am going to be really annoyed. [*Laughter*.] The point is that, if you have an ever-expanding need, at what point does it mean that you just get the whole of the Welsh Government—

[230] **Mr Roberts:** Maybe I can talk about the Office for Budget Responsibility's paper on fiscal sustainability instead, but it makes all the same points as well. Clearly, there is an anticipation by most economists that the proportion of GDP used for those public services associated with an ageing population is going to go up, and healthcare is one of them—it is only one of them. In response to that, we have to get to be far more cost-effective. As Helen mentioned earlier, we have to be prepared to make some of the more radical changes in care. You have touched on the need for even further work to be done on how networks of hospitals work properly, which is a good one. Adam has already mentioned that, actually, we have got to get into very different relationships with our public. The Minister has promoted prudent healthcare—

[231] **Jocelyn Davies:** Can I just say, though, that, over the years, it seems that there has been a quickly expanding budget for health and none of the things that you say should happen was happening during the time when there was plenty of money around. It seems to me that now that we are up against it, we now need this radical change. Why was that not—well, that is not to do with the draft budget. However, is there a point where the beast of health would be satisfied with how much money it had? [*Laughter*.] Some people say that it is a black hole. I am going to call it that. Adam, what do you think?

10:45

[232] **Mr Cairns:** Well, the obvious answer is 'yes'. Let us go back to, say, the Andrews report, which is a very good report. In that report, one of the most powerful things it said was that we need to start to have a conversation with the public about what it can expect and what it cannot expect. Actions have consequences, and if we want to get into a conversation with our public, we need to ask what this means. People may have to wait longer. Some things might not be available.

[233] **Jocelyn Davies:** Is it easier to have that conversation with a budget that just says, 'Sorry, you cannot have any more', and where you have to make hard choices? Otherwise,

you just go on making the easy choices.

[234] **Mr Cairns:** I agree with that. All I would say is that, thinking about the world that we really are in, the public is largely unprepared currently for that conversation to take place. That means that you cannot suddenly turn a page and say, 'As from tomorrow—', so we do have to get into that conversation. As health boards, we have a responsibility to do that, but I also think that politicians have a responsibility to do that, because if we want to confine, as we must, the expansion in healthcare costs, there will be consequences that need to be talked about.

[235] **Jocelyn Davies:** Mike, have you finished?

[236] **Mike Hedges:** Yes.

[237] **Jocelyn Davies:** Okay. We just have a quarter of an hour left, and there are a few people who want to come in. Julie is next, and then we will come to your questions, Nick.

[238] **Julie Morgan:** I was just going to follow up on that conversation, which is difficult to have. I thought that Adam's response earlier to the cancer drugs fund was very powerful, but it is quite difficult to give that message when you are actually meeting people who are very ill.

[239] **Christine Chapman:** On that point, I just wonder how much discussion is had about health inequalities. I know that this is a typical one, but, for example, when people want operations, I think that Cardiff and Vale tell them that they have to give up smoking for a while. Of course, you could argue that that could hit poorer communities where, perhaps, smoking is more endemic. So, I was just wondering how much attention is given to health inequalities. I know that, in my area, Cwm Taf, it is a big priority and there has been a political discussion. What is your view on that?

[240] **Mr Cairns:** It is a really serious problem. There is a 22-year healthy life expectancy difference, depending on which street you live in, in Cardiff and the Vale, and a 10-year absolute life expectancy difference. That is unacceptable.

[241] On the smoking and obesity thing that you talked about, all that we say to people currently is this. 'The evidence is absolutely clear that, if you smoke, you are running a risk when you have your anaesthesia and there is a risk that your wound will not heal as quickly, so we suggest very strongly that you take a smoking cessation course.' At the moment, we do not say, 'And so you must stop'. We also say to people who have a body mass index of over 40 that they must go on a weight reduction programme, for those same reasons: because they are running a risk with themselves.

[242] The logical next step, which we have not taken, would be to say, 'As long as it is not life threatening, we think that it would be right for you to demonstrate that you have stopped smoking', because what they are actually asking the surgeon to do is something that he or she may think is not wise. We do not currently say to a surgeon, 'If someone's got high blood pressure, do you know what, just go ahead anyway?', because they think that that is too risky. There are risks. That is an example of the kind of conversation that we might want to get into. It is about prudent healthcare. This business of getting into the community, and working with and alongside it, is really important because it is so easy to misunderstand this message.

[243] **Jocelyn Davies:** Okay. So, there are clinical reasons, but there is this underlying—. Right, Nick, shall we come to your questions, because, otherwise, we are not going to get through all the questions before the end of the session?

[244] **Nick Ramsay:** Yes, sure. I will be brief. I have a question on the Nuffield report, actually, which Paul Roberts might want to come in on, given that it has been mentioned a lot already. What is your view on the funding gap identified by the Nuffield report, and has the gap grown because of a lack of funding or because health organisations have implemented insufficient reform?

[245] **Mr Roberts:** Am I allowed to comment?

[246] **Jocelyn Davies:** Just call it 'the report'. [*Laughter.*]

[247] **Nick Ramsay:** You are scared to mention the report now, are you not?

[248] **Jocelyn Davies:** Well, it is a good point. Are the problems identified in the Nuffield report the health service's fault, or the Welsh Government's fault for not giving you enough money?

[249] **Mr Roberts:** I am not sure that it is helpful to talk about fault in all of this. We are living in a time when public services are very stretched and public expenditure is very stretched. We talk about austerity, do we not? I think that, very helpfully for those of us working in the health service, the report helps us to give the evidence about the savings and the efficiencies that have already been made in the health service. We have had to do that, as I have already mentioned, to a greater extent than the NHS in the rest of the UK. We know that there is no cavalry coming over the hill in terms of huge amounts of more money into any of these public services, so we have to do even more. I think that, during the course of these questions, we have been touching on what some of those things need to be.

[250] **Nick Ramsay:** Lastly from me, in terms of the National Health Service Finance (Wales) Act 2014, can you give specific examples of how the increased flexibility given by that Act is being used to support service change and increased efficiencies?

[251] **Jocelyn Davies:** Adam, I think that you have covered a lot of that, directly in relation to your health board. Paul, do you have anything to add on that, or perhaps on something more general in other parts of Wales?

[252] **Mr Roberts:** Again, I do think that I have touched on some of these examples already. Certainly, it is easier to quote my own health board. What we have been able to do is use the flexibility to plan certain changes in services over three years and to describe both the costs and benefits of those things happening over three years. Therefore, I think that the budget announcement last week enables us to fulfil some of those plans, because we have obviously held back on some of those commitments. So, those are commitments to make changes in the way that we provide healthcare that bring benefits. However, they might not bring benefits until year 2 or year 3.

[253] **Nick Ramsay:** The three-year programme has really helped.

[254] **Jocelyn Davies:** Adam, do you have something to add to that?

[255] **Mr Cairns:** I just want to put something out there, which I think is an example of how it might work. We have a three-year plan that has been approved. Our three-year plan has been approved on the basis that we did not assume that there would be any extra money. So, we have dug in and said, 'Right, that's 6% then'. As it happens, we are struggling to get the 6% out this year, but that is what we set out to do. There will be other boards that do not have an approved three-year plan, and which may or may not have concluded that there was no money. I honestly do not know. We will be watching very carefully to see how the allocation is played out, for those reasons, as you can probably imagine. However, one of the

flexibilities that we, I think, are being encouraged to believe might be available to those that have three-year plans and have that mindset is that, maybe, we will get easier and quicker access to capital. That might be one of the things that might happen. If that were to happen, that would be very useful.

[256] **Jocelyn Davies:** So, the devil is in the detail for you. Are you able to carry any of this money over to next year?

[257] **Mr Cairns:** We certainly could not. When I arrived in Cardiff, we could not balance in one year. It was just a physical impossibility. So, we have worked through, with the Welsh Government, how we can repair that position over time. As everybody knows, we were in deficit last year, and I was very clear that I wanted to show that we were in deficit, because that is the truth, and so we were sending a strong message inside our organisation that we are living on someone else's money and we had to sort that out.

[258] **Peter Black:** Given the pressures and difficulties that you have in balancing your budget in-year, why is it that some health boards opted for one-year budgets under this new regime to start off with, or have they not even got their three-year plans approved yet?

[259] **Mr Roberts:** I think that the health service has struggled to put together three-year plans that balance over those three years, particularly where they can see structural deficits in those budgets. So, there are a couple of health boards that have had deficits in their budgets, essentially, for some years. The aim of putting something together that, over three years, balances a budget and allows them to have a balanced budget approved in three years has, I think, been particularly difficult for some health boards to do. Bear in mind that this is the first—

[260] **Jocelyn Davies:** Now you can clearly see that deficit. You cannot hide it anywhere.

[261] **Mr Roberts:** I think that it is because there is an expectation with a three-year planning process that your financial plan does bring you a balanced position over those three years, taking one year with another. For those health boards that have had deficits within their budgets for many years, I think that having all the answers ready and in place in a three-year financial service plan is very difficult for them to achieve.

[262] **Peter Black:** And yet—

[263] **Mr Roberts:** I think that they probably needed a longer run-up at it, if I can use that term. These three-year plans were put in place in the space of a few months. I think that they needed a longer run-up to get plans and some agreement about how that can be achieved with the Welsh Government. I am sure that they would have wanted to put in three-year plans—

[264] **Peter Black:** Yet they find it easier to do last minute cuts at the end of the financial year and pull the budget back by deferring operations and stuff like that. Is that a fair way to approach patients?

[265] **Mr Roberts:** I know that Adam has partly addressed this issue in answer to a question that we had earlier. I think that that was a stronger feature of one-year budgeting processes.

[266] **Peter Black:** Yes, well that is what the ones who have opted for a one-year process have done, have they not?

[267] **Jocelyn Davies:** Adam, it is not for you—you are here representing your own body—to defend what others have failed to do**.** Ann, shall we come to your questions? It looks like

we will have to finish after your questions.

[268] **Ann Jones:** Very briefly, it is about what discussions the federation has had with Welsh Government around the requirements of the wellbeing element of the future generations Bill. However, if I could just broaden that out, most of the legislation that the Government is taking forward could have implications for yourselves in terms of additional resources, or could mean that there could be some savings. For example, if we have people in better housing after the housing Bill goes through, perhaps then they will not be as depressed and will not have to access your drugs fund. So, have you made any analysis of which pieces of legislation will assist you and which will be more problematic?

[269] **Ms Birtwhistle:** As I said at the beginning, we represent our members and have a member view on policy issues. We have a strong policy group that looks at legislation that is coming through and at policy and does a bit of horizon scanning, as well. So, yes—. We also respond to consultations and we do our own pieces of background work and policy research. We also work, as I said before, in partnership with other organisations. So, our line is very clear, really, and that is that health—I am sorry to repeat this—is not a standalone issue. Health and wellbeing is reflected in virtually everything that the Government is involved in and virtually everything that you, as Assembly Members, are involved in. We are very clear that there has to be a health impact assessment—although it sounds a bit grand to say that—of everything that is happening here in Government. So, yes, we have continuous dialogue, not only with Government, but with our members, obviously, and with our partners and the wider public. We see that as part of our role.

[270] **Jocelyn Davies:** Ffred, did you want to come in on this point, before we go back—

[271] **Alun Ffred Jones:** No, it is on a different point.

[272] **Jocelyn Davies:** It is a different point. Okay, we will let Ann finish her questions first.

[273] **Ann Jones:** I am fine, thanks.

[274] **Jocelyn Davies:** Okay. Ffred is next, then.

[275] **Alun Ffred Jones:** The support to hospices has been cut drastically—a 76% cut. Can you envisage any knock-on effect on NHS hospitals from this?

[276] **Mr Cairns:** I am afraid that I do not recognise that number. I can only speak for Cardiff and Vale health board. We work very closely with our hospice; it provides a really useful service. As is the case everywhere else, all of our third sector contracts have been reduced in value and that is a reflection of the total amount of income that we have to disperse. What we have asked people to do is to tell us how, just like we are doing, they can do what they are doing to the same level, but just more efficiently. That is the world that we are all in—not just the public sector; everyone is in that world.

[277] **Mr Roberts:** Equally, that is not a figure that I would recognise and maybe we will have to go after this meeting to look at the—

[278] **Alun Ffred Jones:** Well, the support was £6.5 million to hospices and it has been cut by £5 million. I am merely asking whether that is likely to affect—

[279] **Mr Roberts:** Certainly, in my patch, it is a similar story to Adam's. We run the hospices as part of our healthcare system and the same disciplines apply within palliative care areas as apply within other parts of the health service. As we are in other areas of healthcare,

we are looking at different models in palliative care and certainly more integrated palliative care involving community based palliative care as well as hospices, and palliative care within acute settings as well. So, models are certainly changing, but I do not recognise the picture presented.

[280] **Jocelyn Davies:** But you will have individual contracts with hospices. You would buy services—

[281] **Mr Roberts:** In some cases, we run them directly.

[282] **Jocelyn Davies:** You run them directly. Peter, I know that—

[283] **Peter Black:** Do you want me to ask the question on the ambulance service?

[284] **Jocelyn Davies:** Yes, please. We will just have one final question.

[285] **Peter Black:** This is more to Helen than anyone else. Are you able to comment on the sustainability of ambulance services and whether they have the right management and funding in place to meet targets in 2015-16?

[286] **Ms Birtwhistle:** I think that is a really complex question to answer in one go.

[287] **Peter Black:** Indeed.

[288] **Ms Birtwhistle:** Ambulance services are changing; they are being reformed and they are part of the whole clinical response and picture, so, in very much the same way that we have described services generally as changing, the ambulance service has changed and is changing from a scoop-and-run service to very much an integral and clinical part of the way we deal with individual patients.

11:00

[289] The pressures on the ambulance service are particular, are acute and are being looked at, as you know. However, I also think that some of the principles that we have all talked about and that Adam and Paul have referred to around our relationship with the people we serve and with the public is key to the way that ambulance services are organised and, indeed, the way that we use them.

[290] **Peter Black:** Given the way that they are organised, can they deliver those targets or do we need to look at a more local organisation and integration at a health board level?

[291] **Mr Roberts:** Perhaps I could make a comment. What you have to bear in mind is that we are very new into a new model of commissioning ambulance services. The Minister set up the commissioning committee for emergency ambulance services and that has been going for six months, I think, or slightly less, actually, but only a few months now. We have a new ambulance commissioner in place and he is urgently assessing the questions that you are asking. That is probably a question that we will be able to answer in more detail in the near future.

[292] **Peter Black:** Okay. From the point of view of our scrutiny, however, the budget is okay and you think it is a more fundamental and structural issue.

[293] **Mr Roberts:** Certainly, we are not clear about all of the exact allocation, but the commissioning of ambulance services does involve additional investment in ambulance services. The commissioner has to explore—and he is relatively new into post—whether his

assessment is that that is adequate for the needs of the ambulance service over the coming three years. He is in the process of doing that.

[294] **Jocelyn Davies:** Okay. Thank you very much. If there is anything else that we need, perhaps we will write to you. I think you promised to send us one or two notes on things for which you did not have the information at your fingertips. Thank you very much. I think that was a very good session and thank you for being so candid with us.

[295] **Ms Birtwhistle:** Thank you for your support for the NHS in Wales. I hope that today and through our written submission and our evidence, we have been able to demonstrate that the NHS is working hard; it is doing a good job, it is looking forward, and it is planning. We are grateful for the support that you have given, particularly through the planning system.

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

11:02

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

[297] **Jocelyn Davies:** Shall we move into private session, so that we can discuss the evidence? I move that

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

[298] I see that we are all content.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:02.
The public part of the meeting ended at 11:02.