Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd a Gofal Cymdeithasol

The Health and Social Care Committee

14/01/2016

Trawsgrifiadau'r Pwyllgor
Committee Transcripts

Agenda – Cymraeg
Agenda – English

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cynnwys
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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

Alun Davies	Llafur Labour
John Griffiths	Llafur Labour
Altaf Hussain	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Gwyn R. Price	Llafur Labour
Jenny Rathbone	Llafur (yn dirprwyo ar ran Lynne Neagle) Labour (substitute for Lynne Neagle)
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Health and Social Services)
Vaughan Gething	Aelod Cynulliad, Llafur (y Dirprwy Weinidog Iechyd) Assembly Member, Labour (Deputy Minister for Health)
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol a Phrif Weithredwr GIG Cymru Director General for Health and Social Services and NHS Wales Chief Executive
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio, Llywodraeth Cymru Director of Social Services and Integration, Welsh Government

Martin Sollis	Cyfarwyddwr Cyllid, Llywodraeth Cymru Director of Finance, Welsh Government

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

Llinos Madeley	Clerc Clerk
Rhys Morgan	Rheolwr Craffu Scrutiny Manager
Dr Paul Worthington	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:45.
The meeting began at 09:45.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome Members to this morning's session of the Health and Social Care Committee? Can I wish everyone a happy new year, from the beginning, and welcome you back to the 2016 sessions? Can I also welcome the Minister, Mark Drakeford and the Deputy Minister, Vaughan Gething to this morning's session? I'll come back to you in a second. Can I remind Members, please, to turn your mobile phones off, or any other devices that may interfere with the broadcasting equipment? We have no scheduled fire alarms this morning, so if one does occur, please follow the directions of the ushers. The meeting is bilingual. If you require simultaneous translation from Welsh to English, please use the headphone set on channel 1. If you require amplification, the headphones should be set to channel 2. We've received apologies this morning from Darren Millar—no substitute has been identified—and from Lynne Neagle. We welcome Jenny Rathbone as a substitute for Lynne this morning to the committee. Welcome.

[2] Before we start proceedings, I want to declare that my wife is a superintendent radiographer in the national health service, and consequently, these issues may reflect upon her area and her health board.

09:46

Cyllideb Ddrafft Llywodraeth Cymru ar gyfer 2016-17: Sesiwn i Graffu ar Waith y Gweinidog
Welsh Government Draft Budget 2016-17: Ministerial Scrutiny Session

[3] **David Rees:** Can I therefore welcome, as I said, the Minister and Deputy Minister this morning to this session on the budget scrutiny for the health portfolio? Minister, would you like to introduce your officials?

[4] **Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (Mark Drakeford):** Diolch yn fawr, Gadeirydd. Gyda ni y bore yma mae Martin Sollis, sy'n arwain ar yr ochr gyllid yn fy adran i, Andrew Goodall, prif gyfarwyddwr gwasanaethau iechyd yma yng Nghymru ac Albert Heaney, pennaeth yr adran gwasanaethau cymdeithasol.

The Minister for Health and Social Services (Mark Drakeford): Thank you very much, Chair. Joining us this morning is Martin Sollis, who leads on finance in my department, Andrew Goodall, director general for health and social services in Wales and Albert Heaney, director of social services in Wales.

[5] **David Rees:** Thank you, Minister. Can I thank you for the paper you provided to us on our requests for the details identified? It's been very helpful in our preparation for this morning's session, so thank you very much for that. Clearly, there's a large amount, and budget lines, sometimes, are huge for one particular area—the NHS per se. So, we'd like to ask some questions to explore those areas a bit further. We'll go straight into questions and start with Gwyn Price.

[6] **Gwyn Price:** Thank you, Chair. Good morning, everybody. Minister, could we have your views on how successful the implementation of the National Health Service Finance (Wales) Act 2014 has been in terms of achieving expected benefits from a three-year planning horizon and on the robustness of the planning system? Also, what degree of confidence is there about the ability of NHS organisations to ensure financial balance throughout and beyond these three years? There's a mouthful.

[7] **Mark Drakeford:** Thank you very much, Gwyn, for both of those questions. Well, Chair, I suppose I will just begin by reflecting on the fact that we are only just about halfway through the first round of the new three-year regime. We're in the second year of the first three-year cycle. So, any

conclusions that we can draw about how successful or otherwise the new regime has been have to be tentative at this stage, because we haven't even had a single cycle of it.

[8] Chair, you will remember that, when that Bill was in front of the Assembly, the questions that were pursued by Members about it were looking for assurances that we would not allow organisations the advantages of a three-year regime, unless we were properly confident that the plans they presented merited that endorsement being given to them. In terms of the success of the regime, I think it is a success that, in the first year, only four organisations had three-year approved plans, in the second year, the year we're currently in, that's moved to seven organisations with three-year approved plans. We are in the thick of the process of organisations preparing their three-year plans for the final year of the first cycle. I'm hopeful that more than seven organisations will have approved three-year plans in the next round, but I'm absolutely committed to the principle that an organisation that gets a three-year plan will only get it because it's got a plan that is properly approvable. If the plan isn't approvable, it won't be approved by me.

[9] I think it's interesting in terms of the success of the new regime to see that those organisations that have approved three-year plans from a finance point of view tend also to be those organisations that are the best performers in terms of service delivery and the best performers in terms of workforce matters. I think that's another emerging success of the regime, because, as you know, the three-year medium-term plans are integrated plans. Organisations have got to show that they have an integrated plan for finance, service and workforce, and the seven organisations that have got approved plans tend to be at the best end of the spectrum in all of those aspects.

[10] There is more that we want to do. There are more benefits I want to see organisations that have approved plans getting as a result of having approved plans. And, as the system continues to mature—and it is early days in its maturity—I think we will see further benefits that come from having a proper three-year planning regime.

[11] In terms of Gwyn's second question, during the time that I have been health Minister, we have lived within the means voted to us by the National Assembly in both the years that have come to a conclusion, and I'm confident that we will do the same again this year. And, with the resources

that the finance Minister has made available for 2016-17, I'm confident that we will live within our means again. Does that mean that every single organisation will come in on its own budget? It doesn't mean that, and, as I said in front of the committee this time last year, at this point in the current year—nine months into the current financial year—there are some organisations where I'm very confident, at one end of the spectrum, that they will come in on budget, and that's where the majority of organisations are, and there is a smaller number of organisations where I have much less confidence that they will live within the means available to them this year. But, in the round, the organisations for which I am responsible will live within the means available to us.

[12] **Gwyn R. Price**: Could you tell me, Minister, are we working closely with the organisations that are not going to make it at this moment in time?

[13] **Mark Drakeford**: Yes, we work very closely with them because they tend to be those organisations that don't have a three-year plan and weren't able to demonstrate sufficiently to us that they had a plan—. So, they are on a one-year plan, and, in the nature of that, we work very closely with them. One of them is the organisation in Wales that is in special measures. Obviously, the degree of oversight of their activities by the Welsh Government is closest of all.

[14] **Gwyn R. Price**: Thank you.

[15] **David Rees**: John and then Alun on this particular point.

[16] **John Griffiths**: In terms of moving the health sector in Wales to a longer-term view and approach to planning their finances and, indeed, their service delivery, rather than existing on a year-to-year basis, one thing I hear from the health sector is that what would aid them greatly in terms of having that longer-term view is more confidence and certainty in terms of Welsh Government policy and the roll-out of service change—particularly, for example, around the change to community services and when community health centres can reasonably be expected to be in place in terms of the availability of funding and, of course, in the Aneurin Bevan area, the specialist and critical care centre. What I hear is that it's sometimes those uncertainties around timings and availability of funding that create difficulties in terms of taking this long-term view. That's very much about getting their financial projections in place with some confidence as well as the actual service delivery. So, would you accept that it has to be this

partnership working, with Welsh Government being clearer and perhaps being able to give a greater degree of confidence and certainty in terms of when we'll see this transition from pulling services and the resource that goes with it from the specialist tertiary sector into primary care?

[17] **Mark Drakeford**: Well, Chair, of course I recognise the struggle that all public service organisations face in Wales in planning for a future where the only certainty they and we have is that there is less money every year to do all the things that we would like to see done. In 2019, compared to 2009, there will have been a 30 per cent reduction in the capital programme available to the Welsh Government. That is a huge reduction to manage, and it does mean that, every year, we have to reassess the capital programme and put our investment into those plans where health boards have been able to demonstrate that those plans are ready and fit to be invested in, and where they will make the greatest difference to the future health of their populations. The big thrust of the capital programme is to support service change and, in particular, to support the movement of services closer to communities. I have been able, yesterday, to sign off the capital programme for next year. That will give health boards the certainty of knowing the sums of money that have been allocated to them to take forward the plans that are most important in their localities. Nobody would want to argue, would they, that when you are faced with real terms reductions in your revenue budget—10 per cent less than we once had, 30 per cent reductions in your capital budget—every organisation feels the impact of that. Our job as Welsh Government is to try to mitigate it as much as we can, and to provide as much certainty as we are able to, but we can't eliminate the uncertainties that come with managing a reducing quantum against a rising demand.

[18] **David Rees**: We will come back to capital later on this morning. Alun, on this point.

[19] **Alun Davies**: Thank you very much. I think the move to three-year planning was long overdue, and I think the Minister is to be congratulated on the way in which that approach to management is actually being delivered in the national health service. I think that's a great benefit for all parts of it. You were very candid, Minister, in your response about the response of health organisations and saying that many were moving in the right direction. Then perhaps you weren't quite so candid in your response to the question of those that aren't. I would assume that, as a Minister, you are taking quite a muscular approach with those organisations that haven't embraced this way of working, and it might be useful if the committee could understand how

that muscular approach, if you like, is actually being translated into action.

[20] **Mark Drakeford:** Chair, when I was in front of the committee last year, we had this discussion. I was quite happy to name the organisations where I had the least confidence that they were managing to live within their means, and I'm very happy to name them today, because they will come as of no surprise to the committee. The two organisations that will struggle the most to live within their means, and are unlikely to struggle successfully, are Betsi Cadwaladr in the north and Hywel Dda in the west. Neither of them have a three-year plan. We work very closely with them both. At the end of the year, my aim will be to recognise any costs that, legitimately, those organisations can describe to us as being beyond their direct ability to influence.

[21] So, there are some things that we are requiring BCU to do because they are in special measures. Sometimes, the things that we are requiring them to do bring costs with them. So, we are determined that they will strengthen their ability to provide mental health services across the whole of north Wales, and they need extra help in order to be able to do that. Where the costs that they incur are because of things that we are requiring them to do, I will provide funds to them in their accounts to cover those costs. Where there are costs that I believe a better-run organisation would have managed differently, I will not artificially give either of those organisations money at the end of the year to make it look as though they did live within their means, whereas in fact they didn't. If there is muscularity in the system, it is in the way that, last year and this year, I have not been willing to sustain a fiction that organisations have managed to live within their means. So, those organisations' accounts will be qualified at the end of the period by the auditor general. That brings reputational issues with it and other practical issues, too, and those organisations will not be able to escape those.

10:00

[22] In the case of Hywel Dda, equally, where there are costs that the organisation is incurring that we believe should be recognised, we will recognise them. I have more confidence this year than I did 12 months ago, when I was in front of the committee, that the team who are currently in charge of Hywel Dda—their new chief executive and their new chair—have some practical demonstrations, now, of how they are changing services in their area in a way that will give them a path to long-term sustainability. We want to be alongside them on that journey. We want to be supportive of them, as much as we can, without disguising the fact that there are

important things that they have to do if they're to live within their means in the longer term.

[23] **Alun Davies:** In terms of that path, which everybody would welcome and recognise, we understand the issue with Betsi Cadwaladr and we understand—it's been well reported—the actions that the Welsh Government are taking, and I think there's broad support for that across the committee and across the country. In terms of Hywel Dda, if they're on the path to improvement, then I presume that you're not considering similar sorts of interventions as you are in Betsi, but I would anticipate that you are intervening in the way that you've described. As a consequence of that intervention, you will have agreed, with Hywel Dda, a way of working. Do you have a timescale for the delivery of the improvements that you've outlined to the committee today? Are you intervening in a way that implies Welsh Government officials working in Hywel Dda to help them deliver these improvements, or is it more a case of the Welsh Government intervening externally, if you like, without that, sort of, embedded intervention?

[24] **Mark Drakeford:** I'll probably ask Andrew to answer on the escalation issue—where Hywel Dda is in the escalation framework. I'll just respond to the final point that Alun raised. Unlike in north Wales, where we have systematic involvement in the running of the health board in key aspects of its work, our intervention in Hywel Dda tends to be more around specific issues and by particular interventions. So, we have—I hope, helpfully—been playing a part in the mid Wales collaborative, in appointing people to chair that and to try and make sure that it does the job of work we want it to do. In the case, for example, of Withybush hospital, which undoubtedly faced challenges over sustaining its accident and emergency department, the deputy chief medical officer, at my request, acted as a broker of discussions across a number of sites and disciplines in Hywel Dda, in a way that has allowed that hospital to go on providing 24-hour services in the way that the Welsh Government was very keen to see sustained. So, it's on specific issues and for specific purposes, rather than a, sort of, day-in, day-out involvement in aspects of the health board's work. But, on the escalation issue, if you'd like to hear—

[25] **David Rees:** Yes.

[26] **Dr Goodall:** As committee members are aware, our escalation level operates from levels 1 to 4, and 4 acts as special measures. It's important that we use the structural framework of that to give the right support and

wrap it around the individual organisations. In terms of our contact point with Healthcare Inspectorate Wales and with Wales Audit Office in terms of advice and recommendations at this stage, as a result of that, the Minister accepted advice about putting Hywel Dda into the enhanced monitoring stage, which is level 2 out of the four, which was in March this year. So, we've been engaging with the organisation. Yes, it puts further clarity on actions locally, it means, certainly around the one-year plan, that we're very clear on some of the conditional aspects of support that we're looking to give at this stage, so we can set out our expectations, whether it's the development of services, improved stakeholder arrangements or specific issues around, I don't know, unscheduled care and improvement around waiting times, in particular, at this stage.

[27] Actually, the approach that Hywel Dda have taken with us is, sometimes, not just simply to wait for things to deteriorate; they've asked for some very specific aspect of support around unscheduled care. We have opportunities that are available to us, like the delivery and support unit, that we can push in. They've done some work on pathways, for example, as well, but we've also been scrutinising them on the financial side. So, at this stage, it's a combination of using some of our routine contact mechanisms, perhaps having them more frequently. We've just had our mid-year review with them, just a number of weeks ago, before Christmas, and again, we're very clear about our expectations, and for an improvement trajectory in that organisation. We are trying to help to give them some confidence about the plans that they're putting in place, whether that can steer towards a three-year plan or not, at this stage. There are still probably some difficult issues that they need to work through, but our take would be that we feel that the team, certainly in the stakeholder environment, have given us a lot more confidence about where they're going at this stage. They are at level 2 out of 4, so this is not an organisation that is in special measures at this stage, irrespective of the fact that they've got some significant issues that they've got to address and respond to.

[28] **Alun Davies:** And a timescale for the resolution of these issues.

[29] **Mark Drakeford:** Well, in terms of whether they get a three-year plan for next year, which will be a sign of those issues being firmly grasped, I intend to follow exactly the same timetable as I have in the last two years. So, health boards will submit their plans by the end of March, and they will then be subject to internal scrutiny by the Welsh Government, and whoever is in the Government and doing this job after May will take the final decisions on

which organisations have succeeded in getting a three-year plan and which ones haven't.

[30] **David Rees:** The last question on this particular thing and then we'll move on to other aspects of the budget. Elin.

[31] **Elin Jones:** Just to be clear on the health boards with the three-year plans, you're expecting all of those health boards, then, to live within their financial allocation for this financial year.

[32] **Mark Drakeford:** Well, all organisations are on a spectrum of confidence. Of the seven that have approved plans, the majority of them are at the very confident end. There are a couple where we will still be working with them over the remaining three months of the year, but the majority of them, certainly, I feel very confident will live within their means.

[33] **Elin Jones:** You've named the two that you weren't confident in, and it was Hywel Dda and—. Which of the two, then—

[34] **David Rees:** Hywel Dda and Betsi. Sorry.

[35] **Elin Jones:** And Betsi, yes. What did I say?

[36] **David Rees:** You didn't say the other one.

[37] **Elin Jones:** Oh, I didn't say. All right, okay. Which of the two—?

[38] **Mark Drakeford:** I'm very happy to. There's no secret in any of this. These figures are published every month. In the spread of the spectrum, I feel very confident that Velindre, Public Health Wales, Aneurin Bevan and Cwm Taf will live within their means. I'm confident that Powys will live within the means that they have available to them. We are working with Cardiff and with ABMU and I want them to be in the same position. But whereas with the five I've named, I think, I feel that I'm already confident that they're home and dry, the other two we continue to have issues that we explore with them in order to get them to be in the same position.

[39] **Elin Jones:** Okay. That's fine.

[40] **David Rees:** Thanks for that. We move on now to the next area, Minister, and that's to local government support and the social services

aspects. Alun to start on that.

[41] **Alun Davies:** I'm interested in the relationship between the health budget and the local government budget. We're aware of the pressures that the health service is operating under at the moment, and I think we had a statement from the Deputy Minister last week that outlined that, and outlined how well the health service is dealing with that. I think members of staff in the health service are to be congratulated on the way in which they're dealing with the pressures they're facing at the moment. But, in terms of the structural relationship, it's going to be difficult to manage the pressures that we face in January, but also an ongoing relationship with local government in terms of discharge and putting care packages into place, when local government is facing its own significant pressures, and facing real, actual cuts to its budget. I understand that some money's been put aside into the local government budget for social services, but are you concerned that, notwithstanding the budget for social services, they don't exist in a vacuum? They exist within organisations that are under terrific financial pressure at the moment, and I think many of us have been dealing with issues of casework over the recess where people are unable to be discharged because there are not the care packages in place to sustain their needs outside of a hospital environment. Are you confident that this system can be maintained, given the situation in local government?

[42] **Mark Drakeford:** Given that the Deputy Minister put out the statement last week, he might want to just lead off on this.

[43] **The Deputy Minister for Health (Vaughan Gething):** Yes, I'm happy to. In terms of your end point about the confidence in the system, I think there are good grounds to have some confidence about there being a continuation of improvement. That doesn't mean to say there's a perfect system, but it does mean, when you think about where we were at the start of the last year and going into the middle of the year, I think we had more issues of concern around delayed transfers of care. And, when you look at the decisions that we've made in terms of protecting part of the social services spend, that's a financial choice that we've made, but it's not just about the financial choices, it's partly about the recognition of having less resource anyway.

[44] So, a lot of this has been about the practical relationships and the co-operation that exists on the ground, which is why I took a lead, starting with Cardiff and Vale, to look at how they work together and how they use their financial resources, because the obvious point is that all of those

organisations are spending significant sums of money in broadly the same area, and what value do they get from it? We're trying to get over some of the points about protecting different parts of the budget, whether it's health or social services. There's been progress there. With each of the partnerships that I had conversations with, health and social services were in the same room at the same time—I didn't want to have half a conversation, with people saying, 'It's not our fault'—we're seeing progress, and that's really important because that progress means there are fewer people having delayed transfers of care. That does not mean things are perfect, but then if you look at other financial choices we've made, the intermediate care fund is a really important part of it, because it's about incentivising and providing real resource to actually promote the collaboration that we all want to see.

[45] There are really good examples right across Wales where that funding is working. Of course, we've put extra money into the intermediate care fund, both to support successful examples and to develop new models of care. It's not just about health and social services working together, it is about the third sector and housing as well being part of those solutions. So, you can see the financial choices that we're making, about how we've helped to pump-prime and to kick-start that collaboration. You can see the real impact in terms of all of those examples that we could give you of where the intermediate care fund is working, the extra money we've put in as a result of that, and also, when you look at delayed transfers, you see an improvement in the last three or four months together, and I look forward with interest to the figures at the end of this month as well. What's really striking, I think, is that, during winter, we've seen an improvement in delayed transfers of care, and that is not the picture that we see across the rest of the UK. England has seen the worst delayed transfers of care figures for pretty much a decade, and we don't see that here in Wales. So, that is something about our financial choices and seeing health and social care together, and not taking money artificially out of one side of it, and it's those practical relationships as well.

[46] In terms of some of the specific points, it might be helpful to have Albert give you an example from Gwent and some points about dementia care, where we're actually looking at the different way that money's been used in the intermediate care fund, which has had a real impact for those individuals as well. Do you want to visit that?

[47] **Mr Heaney:** Yes, thank you, Minister. Two comments, if I may, before the committee: one is that the auditor general in the report, 'A Picture of

Public Services 2015' published just before Christmas, showed that spending across local government in Wales had fallen less sharply than in most other parts of the UK. That's part of the strategy from Government to support social services financially—the RSG, et cetera—over the last few years, and that's made a significant difference.

[48] In terms of the strategy, the second point, in terms of intermediate care, is that there are lots of really good examples now across the health and social care community of working together in partnership with the third sector and housing that are showing benefits. One of the services that we have visited in the Gwent area is the rapid assessment and intervention department, which is a multi-agency service that's working with people with dementia. What they have shown in the evidence from the intervention around intermediate care and the multidisciplinary approach across the health and social care communities is a reduction in terms of people's length of stay in the hospital setting, and actually faster, rapid intervention in terms of care and onward treatment. So, again, highlighting some real success that's building resilience into our health and social care system.

[49] **Alun Davies:** It's good to hear all of those different projects and programmes, which, I think, are having the impact that the Deputy Minister has described, both this morning and in his statement last week. My concern is about the sustainability of this relationship and the sustainability of the services. That's partly been described, but also in the relationship between local government and the health service, because one thing we're very clearly on is that, whilst local government has had a much better settlement here than across the border, and a significantly better settlement over a number of years, and the same with the national health service—. Is it sustainable to maintain the projects that you've outlined today at a time when local government and local authorities are under huge financial pressures, and may not be able to sustain social services in the way that we would hope and expect over the coming years? Because there's going to be a tipping point, isn't there, when these organisations are not able to sustain social services functions?

10:15

[50] **Mark Drakeford:** Chair, there are three ways, I think, in which we are trying to help provide that sustainability. The intermediate care fund, as Vaughan has mentioned—it will go up to £50 million next year. That's a really significant additional investment. That money is spent on services that

sit right at the cusp of health and social care, and spending decisions are made at the six regional partnership boards where health and social services sit together. That's a really significant extra investment in the sustainability of the services that Alun has mentioned.

[51] There are specific powers in the Social Services and Well-being (Wales) Act 2014 to require pooled budgets. I've already indicated that I intend to use those powers, and I will use them first to require health and local authorities to create a pooled budget for the purposes of residential care services. And, again, that's just a very practical way in which I think we will see better value driven for the investment that both health and social care provide, so they won't be competing with one another, as sometimes happens, for places in residential care; there'll be one budget planned by them both to commission the services that they need in residential care.

[52] And thirdly, in terms of long-term sustainability, the whole thrust of the 2014 Act is about trying to move services upstream into prevention, putting smaller amounts of investment in at the point where those smaller amounts of investment allow people to go on living more independent lives for longer, and turning social services from an ambulance service that arrives after the damage has been done, and into a service that tries to work alongside people to prevent that damage from occurring in the first place. If we succeed in doing that, that will be the biggest contribution of all to long-term sustainability.

[53] **David Rees**: Okay, thank you. I move on to Elin.

[54] **Elin Jones**: Obviously, I welcome the increase to the allocation for the intermediate care fund—I think that's excellent news—but, just following on from the issues that have been raised by Alun Davies, there are undoubtedly going to be pressures on the day-to-day social services run by local authorities. In particular, I'd draw your attention to the fact that four local authorities have had a greater than 3 per cent cut to their budget, and two of those local authorities are in the Hywel Dda area, which we've already discussed as being under a certain degree of pressure from the NHS side as well, financially. What confidence do you have in those authorities that are facing an above average cut to their budgets that they will be able to do exactly what you've been describing here, because there are going to be different pressures in different local authorities?

[55] **Mark Drakeford**: I think for today, Chair, all I can do, really, is to

repeat what the Minister for Public Services said on the floor of the Assembly yesterday—that there is a period of consultation going on on the draft local government settlement, that the points that Elin Jones made very forcefully on the floor of the Assembly yesterday will be part of that consultation, and that we have to allow that consultation to run its course in order to address some of the issues that are always made when you have a period of consultation on a draft, and before the final budget is put before the Assembly for determination.

[56] **David Rees**: Elin, do you want to come back on that?

[57] **Elin Jones**: I guess I'll get nothing more than what you just said. What I'd like you to say, really, is to recognise, where there are additional pressures on some local authorities, that that will put an additional pressure on social services budgets, because social services budgets are, in the main, demand led. We know the nature of the demand, as has already been described to us, and a 3 per cent cut for local authorities will undoubtedly have an impact on social services budgets. But I guess I'm not going to get anything—

[58] **David Rees**: Can I just add to that, Minister? Obviously, we would hope that, once the final settlement has been agreed, you look carefully at the situation in relation to some of those authorities in relation to this particular point.

[59] **Vaughan Gething**: I think it's worth reminding ourselves that this highlights the point that, in any choice we make in allocating budgets between health, local government and any other partner of the Welsh Government, when we be have a reduced amount, there isn't a consequence-free choice that we can make, and this neatly highlights that reality. So, each of the choices we make are difficult and there's no way of contracting out of that difficulty. So, let's not pretend there's an easy choice that's available to us. Everything is going to be difficult and it does rely on us working in a different way that is more effective with a shrinking level of resource.

[60] **David Rees**: We fully appreciate that but, obviously, our job here is to scrutinise how you use your budgets. That's our role. Altaf, do you want to come in now?

[61] **Altaf Hussein**: Yes, thank you very much. Good morning. We know that the vast majority of social services budgets—£1.9 billion—is delivered by

local government within the revenue support grant. That's No. 1. No. 2: local authorities are facing budget cuts and although councils have a duty to provide social services, how the services are provided is up to them. No. 3: I want to make the point that Neath Port Talbot council, in its consultation on the provision of care services, states that they will assess whether care can be delivered by those willing or able to provide care and support before considering whether an individual is eligible for care provided by the council. This is exactly what we warned against. In looking to make cuts, more local authorities may choose this route.

[62] The questions are: how will the Minister ensure that cuts to local authority budgets will not impact on the delivery of social care? That's one question. I'll put two more. No. 2 is: is the Minister satisfied that local authorities will not use the 'can and can only' test to make cuts to their social care budgets? No. 3: what are the outcomes that were achieved by the intermediate care fund in the last financial year and what additional outcome do you expect from the additional £30 million for this programme? Thank you.

[63] **Mark Drakeford:** Thank you for those questions. Let me take them slightly in reverse order, if I could. Outcomes from the intermediate care fund have been very carefully monitored and evaluated. This genuinely was one of those programmes where we put a sum of money from the original £35 million of revenue, as a result of the budget agreement, into evaluation. So, all the schemes that have had funding through the intermediate care fund have been evaluated. They've been evaluated locally and then there's a national level of evaluation as well. So, one of the things that I've said already, Altaf, is that, in increasing the amount of money for next year, that doesn't mean that we will automatically go on funding every scheme that has had money in the first two years of it, because those evaluations will demonstrate those schemes that have had real success and those ideas that have been tried, where what resulted from them wasn't what we had hoped.

[64] Chair, to be honest, I felt from the beginning that if we didn't give the ICF sufficient scope to try some things that might fail, we wouldn't have got the value out of the fund in the first place. The fund was there to try new, creative ways of working across services; not just health and social care but housing as well, which has played a very big part in the ICF, and third sector organisations as well. If you're going to have a genuinely creative approach, we have to recognise that not everything that we try will succeed. That's why the evaluation is important and that's why the schemes that we will invest in

next year will not be identical to the schemes we've invested in in years 1 and 2. What we will have for year 3 is the result of the evaluation, and therefore we now know the schemes that have succeeded. One of the things that I am very keen to see happen is that, where a scheme has succeeded very well, in Abertawe Bro Morgannwg University Local Health Board area, for example, if that scheme has worked well there then that scheme should be replicated in other parts of Wales because it has a proven record of success.

[65] In relation to the question about the 'can and can only' test, I've never agreed myself with those people who say that this a way to try and deny people services. It is an attempt to make sure that we put our investment into working with people's strengths, regarding them as assets, investing in keeping those strengths and assets alive and active in their lives, and then intervening only where we need to. How will Members here have confidence that that is happening? Well, I hope it will emerge in two ways. During Stage 2 of the Regulation and Inspection of Social Care (Wales) Bill I accepted an amendment moved by Lindsay Whittle. I was happy to accept that amendment, and that amendment means that in the annual reports that local authorities have to prepare on their social services functions, they will now have a legal obligation to report specifically on the eligibility aspects of the 2014 Act. That was the effect of Lindsay's amendment and the Government was happy to accept it because people need to be able to see for themselves how these new powers have been used. In any case, the Government is funding an evaluation of that part of the Act and the evaluation will show specific figures for three things: it will show how many applications have been made under the new eligibility regime, how many of those applications have led to a service, and, thirdly, and I think probably most significantly in responding to your question, it will show how many reapplications that are made during the year, because if the 'can and can only' test is being used to turn people away, then people have an automatic right to reapply. And if reapplication rates are particularly high in an area, it would be a matter of wanting to look at whether the test is being properly applied. So, I think we've put in place a whole set of robust mechanisms to make sure that it is absolutely open to anybody to see how the new eligibility rules are being applied and that they're being applied in the way that the Act intends and not in the way that some people fear they might wrongly be used.

[66] **David Rees:** Okay, thank you, Minister.

[67] **Lindsay Whittle:** Sorry, could I just quickly come back on that? The eligibility criteria, which you did accept is extremely important—monitoring it

after the event means that there will be people, perhaps, suffering whilst you're monitoring and perhaps not receiving the services. How do we look after those people? Sorry, Chair.

[68] **Mark Drakeford:** Well, Chair, I've never accepted that the Act is likely to work in that way. The Act will take forward the services that people are already receiving and the annual review of the package of care that somebody is currently getting will be no different under the new Act than it had been in the previous one. It will happen on that 12-month cycle as before. What we hope will be the case is that those needs will be responded to in a different way. They will be responded to in a way that doesn't treat people who come through the door as a set of problems to be solved and to be fitted into services that the local authority already has. The people who come through the door will be asked the question, 'What matters to you?', and the package that is provided is designed to maximise that person's own enduring ability to do what any one of us would want to do, which is to have the maximum control and decision making over our own lives. I think that that's the way the Act is structured and that's the way the Act will work.

10:30

[69] **David Rees:** I thank you, Minister. Obviously, there are other Members who want to ask questions. I'm conscious of the time, and we have quite a lot to still go through, so I want to move on to look at prudent healthcare and prevention. I will start with Jenny.

[70] **Jenny Rathbone:** Well, my first question, really, is to go back to the—

[71] **David Rees:** No. Can we stick to the agenda? We haven't got a long time.

[72] **Jenny Rathbone:** This is prudent healthcare. How well are both health and social services using the voluntary sector for what I would describe as 'good neighbour services'? The average age of people in hospital in Cardiff and the Vale is 84 years. I presume it's the same, roughly, elsewhere. For those who don't have close family members nearby, how well are we using the voluntary sector to do what would normally be done by relatives to ensure that they are going back to a warm home and that they have the groceries they need for the first few days out of hospital, et cetera? From your analysis of budgets and how well health boards are using budgets, could you give us an example of that?

[73] **Mark Drakeford:** I think, probably, there are two strands that I could specifically identify—one in the social services field. Members will recall that, in taking regulations through the Assembly in the autumn under the 2014 Act, one of the things we have done is to strengthen the representation of third sector bodies at the regional partnership level. We strengthened their representation there very much in line with the points that Jenny has just made, to make sure, in the way that the 2014 Act works and in its preventative ethos, that third sector organisations are full partners in the delivery of those relatively low level of intensity services that help people to go on managing other aspects of their lives for as long as possible. We did that because the third sector was very keen to be better represented. When Gwenda Thomas—who, on behalf of the Government, has been going around to visit all of the regional boards—comes back to report to me, she says that she feels that the third sector is genuinely engaged at that spending decision level.

[74] Then, the second thing to say on a budget point, which maybe took me slightly by surprise but in a positive way, is that the £6 million that has gone directly to clusters in the health service this year—there are 64 clusters, each of them now with of a budget of their own to spend on priorities for their areas—more clusters have ended up spending money in third sector services than I probably would have anticipated in the first place. So, we've got some good specific examples there of primary care organisations commissioning services from the third sector in order to bolster what they are able to do to help people continue to live in the community.

[75] **Jenny Rathbone:** Thank you. That's a very interesting answer. Moving back to the headline of prudent healthcare, which is that about 20 per cent of what health services do is either doing no good or doing harm, how well are health boards doing at driving out those activities? Obviously, the sorts of things that get talked about are over-prescription of antibiotics, and over-referral for tests by primary care when it is clear that that wasn't necessarily needed. Could you just say something on that?

[76] **Mark Drakeford:** Sure. I think this last 12 months has been a very fertile year in some of the things we have been able to see emerging in order to address exactly those issues. We've worked closely with NICE—I have a meeting with the chief executive and the chair of NICE in the next week or so—to strengthen the advice that it provides to health bodies on things that they should not be doing. So, there are about 650 pieces of advice that NICE

provides on things that don't have a positive impact on patients and, therefore, ought not to be routinely undertaken. They tend to get much less attention than those pieces of advice that NICE gives on all of the things that we should be doing, but we want to foreground what, in health-service speak, are called 'interventions not normally undertaken'. All health boards in Wales are strengthening the advice that they provide to clinicians to make sure that they are aware of that very significant body of advice and then apply it in the work that they do.

[77] Moving forward, we're part of the Choosing Wisely movement, which is an international movement. We have a Choosing Wisely Wales organisation. I have been very keen that it is clinically led—that it is not led from Government. So, it is the Academy of Medical Royal Colleges in Wales who are taking the lead in the Choosing Wisely movement, because Choosing Wisely is peer-to-peer advice. It is your peers who you regard as authoritative in your field who give you advice about things that you may have done in the past but where best evidence now tells you that ordering those extra tests—. Actually, every test you do carries a risk of one sort or another, and, if there is no benefit to the patient in ordering it, it really ought not to be routinely part of the repertoire of that practitioner. I'm very cheered up by the commitment that we've seen from clinicians across Wales to being part of the Choosing Wisely movement.

[78] Then, thirdly, particularly in the Aneurin Bevan health board, we've seen a very strong participation in an international group of people, led out of Harvard, which is looking at the way in which a focus on outcomes changes inputs. If you focus on the things that matter the most to patients, then the choices that are made along the whole pathway are very different. So, to give you just one example from Aneurin Bevan, they have a new system of dealing with osteoporosis of the knee, which, historically, may well have led you fairly rapidly to a knee operation. Now, all patients who wish to participate, and most patients do, have a group session in which all the different options that are available for dealing with that condition are explained to people. People have the chance to discuss individually which choices might work best for them in terms of what is important to them, then people make the choices of the sort of treatments that they would prefer: pain management, physiotherapy and surgery—it's there as one of the range of options for everybody. And it is very interesting to see how patients default to prudent decisions. They do not, on the whole, default to the more intensive and intrusive forms of treatment. They tend to prefer those treatments that conserve the ability they have and allow them to go on

managing for longer. As a result, fewer things that are not effective are being done and more investment is being made in the things that matter the most to patients.

[79] The work that's gone on in Aneurin Bevan is being recognised internationally. A paper a Harvard review published at the end of November identified the work in Aneurin Bevan as one of the five best examples across the world that they could identify in terms of a prudent approach to choices that people make about the treatments that are available to them.

[80] **Jenny Rathbone:** All that's fascinating. Is anybody doing an analysis of how that's saving resources and enabling health boards to redirect them to other things?

[81] **Mark Drakeford:** I think Aneurin Bevan is in the best place there, because they are able to track costs against choices as well. The aim of it all—the aim of the prudent healthcare movement—. It's a best-value movement. It's just trying to make sure that, in an era when money is going to be continuingly short, we shift resources out of things that have the least impact and invest that money instead into the things that do the most, in terms of the things that matter to patients. I think you can see it financially, but it's a service-driven model, not a financially driven model, but it has financial consequences in the way that Jenny just described.

[82] **Jenny Rathbone:** Thank you.

[83] **David Rees:** John.

[84] **John Griffiths:** In terms of prevention and spending wisely in terms of the resources available, I think we all know that it's very difficult, actually, for health boards to find flexibility in their budgets to move spend from reactive policies to proactive policies, because, obviously, they have to cope with what's coming at them on a daily, weekly, monthly, yearly basis. The same, I'm sure, is very much the case of the health department here in the Welsh Government as well. But nonetheless, much of what we discuss illustrates the importance of making that shift as much as we can. I know the NHS Confederation has pointed to these difficulties for health boards in terms of that lack of flexibility. So, I think some of what we've discussed has shown that resource is being made available in our particular schemes to try and move us on to a more preventative model, but there are those great difficulties.

[85] In terms of physical activity, I'm quite interested in that, Minister, as you know. People sometimes say that it's only one part of the changes to lifestyle that we need in Wales, and I'm sure that's true, but I think if we do get people more physically active, it has good knock-on effects in terms of their general attitudes. They may well then be more careful about what they eat, what they drink and whether they smoke and so on. So, I think it's part of a progressive package, as it were, that would lead us to healthier lifestyles, which would ease the pressure on the health service. In short, Minister, I think there's a sense that, because of the ageing population that is with us, and will be increasingly with us over the years to come, there is need for big thinking around these issues and major change and a real transition. I just wonder if you could tell the committee a little bit about some of the initiatives that are in place, because I know that there are pilot schemes—some of them in my area—and just what process would be involved in trying to make this change?

[86] **Mark Drakeford**: I'll start off, and then others may have things they will want to add. The challenge, John, I think, is to find a way of moving beyond a lot of very good and committed initiatives to try and persuade people to be more active and to make that more into a large-scale change movement. So, as you say, we've got loads of things that go on, with some fantastic people involved in them, but the health service makes some investment and the social services makes some investment in. So, we work with the Canal and River Trust, for example, who have facilities that go through some of the most deprived communities in Wales, to persuade people to take advantage of that just everyday type of exercise that you can get by being out walking. We work with the Ramblers Association, with people who volunteer to run walking clubs, particularly for people who've had cardiac conditions and so on. We have the exercise-on-referral scheme that the health service very specifically funds. As part of the Gwent osteoporosis of the knee scheme, one of the things that's on offer to people as a choice is an exercise regime. When I was speaking to the GP who has overall charge of it, she said to me that she still runs up against a lot of people who believe that the best way to cope with the problem, if you've got a problem with your knee, is not to use it—you know, that the less you do the longer it will last, whereas actually, these days, the best advice is, 'The more you use it, the more use you'll get out of it'. So, one of the specific choices that you can make in that programme is to go on to a tailored programme of exercise that the health service oversees to allow you to make best use of your abilities.

[87] How do we, though, move beyond all those small-scale initiatives to persuading people that if they themselves invest in those choices, that will make a difference to the long-term health that they will enjoy? That's what the prudent healthcare message is: that, as well as all the things that the health service can do, everybody has a responsibility in relation to smoking, drinking sensibly, eating as well as you can, and taking some exercise, because all of those things make such a big difference to your own individual chances of avoiding avoidable harm in the future. I don't think we have those answers yet. There are some examples in other parts of the world, and Public Health Wales is very actively engaged in trying to devise large-scale change programmes that we could put into practice in Wales, but we are not there yet. We have a lot of those initiatives that you talked about; they don't yet amount to a large-scale effort of the sort that we know we need.

10:45

[88] **John Griffiths:** Just to quickly follow up, Chair, where local health boards in areas of Wales are trying to work in this way, Minister, working with the local authority, with the leisure and sport sectors and sports clubs, housing associations, you know, because it is a wide picture, as you suggested, it's about the environment and the way the environment is shaped and whether that's conducive to walking and cycling rather than car use—. The more you think about it, the more you understand how wide-ranging it is. Where health boards and local authorities and the sport and leisure centres are taking initiatives locally and trying to get around a table, which I'm trying to do locally in Newport at the moment, is there enough in place from Welsh Government that provides incentives and recognition to enable that to happen and to foster that, do you think?

[89] **Vaughan Gething:** I think there is, but it's really about what encouragement and recognition that we give to those people who are successful in getting partners into the right place and agreeing how they'll use their differing budgets for the same purpose. Lots takes place at different levels right across Wales, not just on physical activity and the way that's been recognised, but when you think about a group of orthopaedic patients, every health board runs a lifestyle management programme of some kind. There's lots of similarities in it, but there are some different points as well.

[90] So, we're trying to understand what works most effectively, what are

the success rates of each of the programmes and then getting a better national picture of what that looks like and what we need to see more of moving forward. All of those choices are choices that the health service, with partners, can help people to make, but people have to make those choices themselves, and that's why there's an obvious caveat around what success we can get, but we think there's good evidence already that there are some common elements in each of those lifestyle management programmes that we would and should want to replicate.

[91] Equally, in the different pathways that we have, as we've been describing, not just in Gwent and the example about knee surgery and potentially avoiding knee surgery, but, actually, there are other examples too in a whole range of things, where going to see a different form of intervention first can make a really big difference, not just about the sort of interventions undertaken and the value of them, but the different lifestyle choices that people then make as a result of it. I think we need to be better at understanding why that works, then describing why that works, because, often, the most sceptical person of whether it'll work is the patient themselves—the citizen who comes in with a different view about what they need. When you think about what they want to be able to achieve and the outcome they want, actually people then end up making different choices that have a better outcome for them and it's a better use of money for the health service and its partners.

[92] **David Rees**: Can I ask, therefore, because obviously, we are in a budget scrutiny session, whether you have sufficient allocations within the preventative budget to take that forward?

[93] **Vaughan Gething**: I wouldn't say we have a preventative budget, because so much of what we do is about prevention. When I was in a different role, I had this conversation with the Minister, about how much of what the health service does is prevention, and so much of it is. It depends where it is—is it primary prevention, is it secondary, is it tertiary? If you think about lots of programmes that are primary prevention, think about vaccination, for example—probably one of the best examples of it—we're actually doing incredibly well, and we're maintaining our immunisation budget, taking advice from the relevant joint committee, whereas in England, vaccination budgets are reducing as a result of the recent spending decisions made there.

[94] So, I think we have a good story to tell about our focus on prevention,

and the budget choices are following the policy choices as well. So, I think there is consistency in what we're doing, but we also recognise, as we've said several times before, there's plenty of challenge in all of this too. Think about the different programmes we run in trying to persuade people to make different choices. Smoking is falling. How much of that can you ascribe to the programmes we run and fund and how much of that is more generally about the different choices people make? You can't then say, 'I can ascribe x per cent of the fall in the number of smokers to the different programmes we run'. That's really difficult to do. We'd all like to be able to do it, but if you look at where we are on a range of those things, you'll see the levelling off in the rate of obesity as well. How much of that is about the choices we're making in the way we use health spend? How much of that is about our campaigning on the public health message? I think we can be clear that that's part of the picture and reducing spend in those areas and making different budget choices is not likely to lead to an improvement in those areas. So, I think we're making the right sort of choices here in Wales, and we'll see contrast in other parts of the UK and the impact that will have.

[95] **David Rees**: Okay. Lindsay.

[96] **Lindsay Whittle**: Thank you, Chair. With respect, how can you justify—? You spend hundreds of millions of pounds each year on preventative services and you've cut back. So, I have to ask, if I'm scrutinising a budget, if you're cutting it back, then clearly the money wasn't effective. You've all given us examples of very good practice and we said, 'Ooh' and 'Ah' in all of the right places—most of them in Aneurin Bevan health board, which is the area I represent, so I'm delighted. But if you're cutting back, then clearly some guidance and advice must have been given to you that these preventative services weren't actually saving you money.

[97] **Vaughan Gething**: Sorry, we're not cutting back. The example I gave was that we're maintaining our focus and our budget choices here in Wales, whereas in contrast in England, public health and preventative programmes are suffering a significant budget cut. So, I'm highlighting the fact we're making different choices to England.

[98] **Lindsay Whittle**: Well, the Wales audit report says you've cut back 16 per cent from 2013-14 to 2014-15. That's the report that we have here. You've cut back from £147 million to £122 million.

[99] **Vaughan Gething**: Which preventative services are you talking about?

[100] **Lindsay Whittle:** It doesn't highlight that. It's 'Supporting the Independence of Older People: Are Councils Doing Enough?', a report by the Wales Audit Office.

[101] **Vaughan Gething:** Well, we talked earlier about the difficult choice between council budgets and what they do and what health does in partnership with them. That's part of the difficulties of the choices I thought we ran through earlier about there not being a consequence-free choice. If you put more money into health, that has a consequence in local government. If you put more money into local government, that has a consequence in health. Part of the challenge is, with all the budget choices we have made, how we make sure we get better value from them. The Minister earlier was talking about different choices we expect to see made between health and local government, and the points about some of the structural changes, but a lot of this is very practical and about how people use the money that's allocated to them. It's rather difficult for me to deal with the point you've raised from a report—

[102] **David Rees:** It's in the report, and I think you might be able to identify those areas in that particular report, but I think it's also linked very much to, perhaps, some services public authorities deliver, which may not necessarily be under the social services or the health agenda but may have a preventative impact upon those agendas.

[103] **Vaughan Gething:** I see.

[104] **Mark Drakeford:** Could I offer to write to Lindsay on that specific point? I don't have the argument properly in my head today, but I'll certainly look at the reference that he's given us, and we can—. But, in general, I just want to say—it's an important point to make, isn't it—public health in England has had a £200 million cut in-year this year and has huge cuts facing it again next year. In Wales, we've made no cut at all to Public Health Wales, and I don't intend to make any cuts at all to it next year. In tough times, that's a recognition that, although there are very difficult choices, as Vaughan has said, I want to see us going on investing in the preventative and public health agenda, because that's where we see the long-term benefits in terms of what vaccination provides and what screening provides. You can cut them in the short run and you'll pay the price, definitely, in a few years' time. As much as we're able to do it in Wales, I don't want to see us going down that route.

[105] **Lindsay Whittle:** I accept, certainly, what the Ministers are saying here, and I'm not trying to catch people out, please believe me. For me, the preventative agenda is, possibly, the most important, because it should be giving us savings in the medium to long term. We know that, in the medium to long term, money is going to be tighter still, so anything that we can do to prevent that extra spend in the medium to long term right now is very, very important. I think we need an analysis of all of the money spent on preventative services to ensure that we are getting value for money. It's no good giving out leaflets to people, saying, 'You've got to do this, you've got to do that.' There are many people saying we live in a nanny state, and the leaflets are part of the nanny state, I guess. But, it's the practical issues—the examples that the Ministers have quoted here and John Griffiths has quoted—that are very important for me.

[106] **Mark Drakeford:** Can I offer just one example to back up what Lindsay has said? The rotavirus inoculation, which is a new vaccination that we've offered in the health service in Wales over the last year is for infants. The number of hospital admissions that have been avoided as a result of being able to offer that preventative spend has been enormous, and we're able to identify those figures very specifically. So, you can see the return. As you say, normally it's medium to longer term; sometimes, you can see it the next year.

[107] **David Rees:** I've got three individuals who want to ask questions, and I ask that they be very short and sharp questions, please, because of the time and because we still have a large proportion, and I want to move on to Kirsty then. So, Jenny, Altaf and Alun, single questions, please.

[108] **Jenny Rathbone:** You told us earlier that Public Health Wales has a satisfactory budget solution. Could you explain to us why they propose to cut their breastfeeding co-ordinator, given that breastfeeding rates continue to be a big challenge in many of our communities?

[109] **Mark Drakeford:** Andrew may have more detail, but my understanding is that what Public Health Wales is doing is moving the budget that they have precisely because breastfeeding rates in Wales are not where they need to be, and the way that they have done it up until now has not had the success that we would like to have seen. So, in budgetary terms, they intend to invest more in breastfeeding than they have in the past, but they're going to do it in a different way, and hopefully that will be more effective in driving up

breastfeeding rates.

[110] **Jenny Rathbone:** Thank you.

[111] **David Rees:** Altaf, a quick question.

[112] **Altaf Hussain:** Thank you. I just want to make two points, really. At present we're seeing that bedside medicine has been taken over by bedside finances. Now, Lindsay wanted to make a point about what we are doing, and your interaction about the physiotherapy started specifically for knee patients. We know we have generic referral forms that go into the hospital and are picked up first time by the physiotherapist. Previously, or what should be happening is that it should be going to the clinician, and it should be the clinician who is then prioritising the treatment. It is the other way round here. Now, it has a relevance. Its relevance is that it takes a surgeon 20 years to know when to operate and it takes him 40 years to know when not to operate. What we see at present is that younger patients are being operated on unnecessarily. Now, it tells us about the clinical knowledge of these doctors of the conditions—whether that is the royal college that should be taken to task for that. No clinician at present is touching the patient, whether it is because they have a 10-minute slot, or anything—. It's not acceptable. I just want to make that point.

[113] **Mark Drakeford:** I think that is very interesting. I very much like that—20 years to know when to operate, and 40 years to know when not to.

[114] **David Rees:** Alun, a quick question.

[115] **Alun Davies:** One of the most impressive preventative projects that I've seen is the one being piloted in Blaenau Gwent, which the Deputy Minister launched last year. I understand that it's now being rolled out in Caerphilly as well. Can you reassure us that the project will be funded and will continue to deliver results over the next few years?

[116] **Vaughan Gething:** Yes, we've allocated £720,000 for the inverse care law programme between Aneurin Bevan and Cwm Taf. So, our commitment is there, and clear in budgetary terms, and we look forward to seeing more outcome evidence, and not just outputs—the number of people going into the programme—but what that means in their own health outcomes as a result. I think it's a really good example of looking at evidence, what you then want to do as an intervention, then having some financial support to be

able to do it, going out and doing it, and then being able to see at the end of it what has been the outcome for the health of that population as well.

[117] **David Rees:** Thank you. I'll move on now to the section on the resource allocation and primary care funding. Kirsty, do you want to lead on this?

[118] **Kirsty Williams:** Thank you. Minister, back in the summer of this year, you wrote to the committee to say that work regarding financial flows across health authority boundaries had been going on for some time, yet no principles of agreement had been reached. Have new principles for financial flows across health board boundaries now been reached and, if so, how will that affect allocations for 2016-17?

[119] **Mark Drakeford:** Thank you. I'll ask Andrew to pick that up because he's been leading on it.

[120] **Dr Goodall:** The work is not yet concluded. We've been given updates and we have the NHS board next Tuesday, which is receiving an update from the collaborative that has been helping to facilitate some of this. We've been really concerned, given of course that there are financial arrangements in Wales for organisations to deal with each other where their patients are flowing over boundaries, not to interfere with some of those mechanisms. But we've also been very clear about not wanting to introduce an industry around this to ensure that the contracting, if you like, dominates the discussion and that there is a focus around individual patients. In fact, there have been some aspects of the change in financial flows that are less about the services that a patient will go in to access, and more about the implications where alternatives are being put in place and actually the demand is being managed. In fact, Powys is a good example of that, with some of the work that they've been doing around the virtual ward. The impact on emergency admissions just changes the nature of some of the discussions that are taking place at this stage.

[121] But we do have some arrangements that are in place that show that there are some differences being taken forward. Of course, some broader service areas like renal networks have had to facilitate some of these changes. Even on the child and adolescent mental health services network, we've got lead organisations trying to broker those arrangements, and the way in which the specialist services committee works as well is to focus on some of these collaborative arrangements.

11:00

[122] I think, from a more routine service aspect, there's some good learning in Cardiff and Vale as well, with some changes that they've put in place around upper gastrointestinal services and movements there that have located them in Cardiff, where not only were the financial arrangements done in a way that was in line with the planned system of care, rather than just a tariff-based system, but in fact the outcomes two or three years down from those arrangements have actually shown an improvement in patient outcomes, mortality, and on length of stay as well. So, at this stage, not being satisfied with the progress in terms of influencing 2016-17, the year, we're mindful to not introduce an industry, but we actually have an update that we're receiving next week as chief executives around the table on those flows from the collaboration at this stage. I'm very happy, Minister, to follow that through with some further advice. I don't think it's going to be in a position to influence the start of 2016-17, but I think we'll be looking to try to have some influence during that financial year on some changes.

[123] **Kirsty Williams**: With all due respect, these discussions, and the acknowledgement that something needs to be done about introducing some transparency into these arrangements, have been a commitment from the Government over a number of years, and it's disappointing that we still haven't been able to reach principles of agreement. When do you expect to be able to, with health board colleagues, reach principles of agreement around financial flows?

[124] **Dr Goodall**: My hope and expectation is that, by the start of the financial year for 2016-17, we'll be able to do those, that we can start using them in some aspects on the system, but it's not going to be in a position, I don't think, to directly influence an allocation process, for example, that would be able to support the budget at this stage. But my wish, working with the service on this, is that we actually at least have the principles outlined within the course of the next three to five months so they are available to be used.

[125] **Kirsty Williams**: Can I move to the issue of primary care and the resourcing of primary care services? In this financial year, the Government made an additional £40 million available for the development of primary care services in line with the policies in the primary care strategy. What outcomes do you believe have been achieved as a result of that £40 million investment?

My understanding is the Government intends to make that money available again in the new financial year. How will the learning from this year influence allocations for next year, and when will the Minister be in a position to outline how that £40 million for primary care will be divided for the new financial year?

[126] **Mark Drakeford:** Thanks to Kirsty for that important set of questions. Yes, first of all, to confirm, the £40 million will be available again next year, so it's recurring money. In the same way as I said with the intermediate care fund, that does not mean to say that I am guaranteeing that absolutely everything that has happened this year will happen next year. Some spend this year has been time-limited in any case, but we, again, want to learn from this year's experience of what has worked the best in order to take that forward into next year.

[127] Where I think the greatest change has been seen has been in the investment that the money has made in diversifying the primary care team, and that's because, as Kirsty will be very well aware, there are some parts of Wales where the ongoing recruitment of GPs is a challenge, and where GPs who are newly coming into the profession don't always want to work under the arrangements that have been there for the last 40 years. So, the greatest areas of investment have been in new players in the field. This time last year, I don't think we probably had one, and now we have 50 clinical pharmacists working in primary care in Wales. I think that's a major development, and I am very keen that we now have a better collective sense across Wales of the maximum impact that that role can make, because, although there are 50 individuals, they are being deployed in slightly different ways in different parts of Wales, and I want to make sure we learn from that and get the most we can out of them.

[128] We have new practice-based social workers being employed through cluster money in some parts of Wales; we have new advanced practice paramedics in primary care; we have new advanced practice physiotherapists, who, doing musculoskeletal work, are able to take very large numbers of appointments that previously would have gone to a GP first in order to be referred to that physiotherapist—they can go directly to them. There's a major investment in the upskilling of the primary care nursing profession, so that they can do more to see patients directly. In Powys, we will have the first physician assistant in post in Wales. I'm looking carefully at how physician assistants are being used across the border, and, if they are a genuinely new role and if they bring people who we otherwise would not have as part of the

primary care workforce, then I'm keen to see what we might be able to do to take that further, too.

[129] Then, Chair, finally, as well as new individuals, the money has been used to support new services. So, there's, I think, an excellent example in BCU where they've used some of the money to work with nursing and residential care homes around end-of-life care. When the scheme started, 22 per cent of all deaths in the 11 residential care homes were taking place in hospital. Six months after the investment, that's down to 8 per cent. Forty three per cent of residents in those care homes at the start of the process had advanced decision documents in place. At the end of it, 83 per cent of them have plans in place that tell the health services how they would want their care to be managed at that point in their lives.

[130] There are many, many examples: I'll just give you the one more, because it's relevant to Powys particularly, which is the £0.5 million from the £40 million that's being invested in new wet age-related macular degeneration services. Six years ago, an injection to prevent sight loss from wet AMD took place in a hospital theatre under general anaesthetic. Now, it's going to be delivered in primary care opticians close to people's homes, using specially-trained nurses who are able to provide it. We'll be doing that on a pilot basis in four health boards, of which Powys is one.

[131] So, lots of what the primary care fund has done has been in audiology, in eye care, in dentistry to a smaller extent—all those things that are part of a wider primary care family to strengthen services closer to home.

[132] **Kirsty Williams**: At the same time, what we have seen, though, is services that were previously delivered under the general medical services contract being offloaded by primary care, who claim that those services were never covered by GMS spend, therefore driving costs in other parts of the system. What discussions are you having with the representatives of primary care about what constitutes GMS?

[133] **Mark Drakeford**: Of course, we are engaged all the time with the General Practitioners Committee Wales in discussions about the contract; we have a two-year agreement with GPC Wales in terms of the contract for this year and next year, so we don't have an immediate opportunity to address some of the issues that have emerged, particularly in relation to hearing issues, which I think are absolutely solvable and need to be solved so that people aren't sent into hospitals for routine things that could be done at

primary care level. But the development of primary care audiologists, which has been taken furthest in BCU and in Aneurin Bevan—I beg your pardon, in ABMU—I think will mean that we will have a new cadre of people who are able to provide some of that care at primary care level, which won't rely on GMS to do it. Because if part of our big strategy for primary care is to make sure that doctors are not routinely doing things that you do not need a doctor to do, to free-up the time of the GP to do the things that only the GP can do, then some of the things that people are being sent to hospital for now, they don't just not need a hospital doctor, they don't need a primary care doctor either; they need a primary care audiologist, who can do some of those things. That's the way I think we will see that service develop.

[134] **Kirsty Williams**: Thank you.

[135] **David Rees**: Elin?

[136] **Elin Jones**: No, that's okay.

[137] **David Rees**: Just on resource allocation, Minister, obviously in your letter to the committee you indicated that the additional £200 million had not yet been allocated. I'm not asking whether you have done that yet, because the letter only came in recently, but do you have an indication as to a timescale when you'll be in a position to identify the allocation?

[138] **Mark Drakeford**: I'll ask Martin, because I think we have.

[139] **Mr Sollis**: We have. We issued an allocation letter on the £200 million just before Christmas, and we'll be updating that with some of the other issues, such as primary care and other issues, before the start of the financial year.

[140] **Mark Drakeford**: So, the £200 million went out on the normal, population-share, Townsend-adjusted formula basis.

[141] **David Rees**: Just out of curiosity—. We haven't seen that. Is it possible to send a copy to us?

[142] **Mark Drakeford**: Of course it is, yes.

[143] **David Rees**: Thank you. We move on, therefore, to questions on the costs of legislation. Altaf.

[144] **Altaf Hussain:** Yes, about the litigation, it's not well described here what the litigation is coming from. I know there can be a clinical background, it may be a management background, or it may be the patient himself who had not been telling what he had been going through. So, that background could have told us how we could improve our services and save that money. I don't know how this—. Say, for instance, we are making the offer of redress where harm has been done clinically. What happens to those clinicians who have done that harm? We never know about those things. We don't know how we address those and whether they are still there in the process doing the same harm. What's your opinion about that?

[145] **David Rees:** Yes, it should be the questions on the risk pool and the litigation costs and the actions also taken as a consequence of some of the issues that arise from that.

[146] **Altaf Hussain:** It is a huge issue, really. We are paying a lot of money.

[147] **Mark Drakeford:** Of course. Thank you, Chair. Altaf Hussain is absolutely right, it is a lot of money, and money that is a source of anxiety to me. We've done some work to look to see whether Wales is an outlier in all of this, whether things are worse here than they would be elsewhere. And, although it's not a great deal of comfort to us, at least that research is showing that our position is broadly comparable and probably slightly better than it is in other parts of the United Kingdom. So, since 2009-10, the number of claims in Wales has gone up by 37 per cent. It's gone up by 42 per cent in England. The cash settlements have gone up by 23 per cent in Wales, but have gone up by 48 per cent in England. It's still a lot of money and it's still a source of genuine concern to us. What is driving it? Well, I don't know to what extent, but I don't think we can ignore the sort of litigious culture side of it, and the fact that there are law firms who are looking for business in this area in a way that might not have been the case in the past. There's the fact that, if something catastrophic goes wrong in the treatment of a child, for example, modern medical care means that that person is still likely to go on living for a lot longer than they might have done not that many years ago. The settlements that the courts are making are reflecting the fact that care will be needed for longer, and that means more costs.

[148] The Department of Health in England has carried out a pre-consultation exercise, and we believe are about to move to a full

consultation, looking at the disproportionate level of legal costs involved in settling claims of low value. So, the money that ends up in the hands of the patient is relatively small, but the legal costs involved in getting to that point seem disproportionately high. If there's action that we can share with the Department of Health in making a difference there, we will.

[149] The one thing I want to say to Altaf's point about the learning that comes from it, and how do we make sure that lessons are learned from the incidents when a risk pool payment is made: well, we've transferred the cash-settlement budget to LHBs themselves to make sure that they have a direct interest in those costs and ownership of them and we always make sure that no reimbursement is agreed to the LHB from the risk pool unless they can demonstrate that they have taken remedial action to address the issue that led to the costs in the first place. So, it isn't just a matter of the claim being made and the money goes to the LHB. They don't get the money until they can assure the risk pool organisers that the causes that led to the problem in the first place have been addressed and, as far as possible, put right. So, we do attempt to create a circle of improvement, rather than just thinking of these costs as inevitable and unavoidable.

[150] **David Rees:** Okay. Thank you. Time-wise, let's go to the last topic—but we have more—capital. Elin has a question on capital, followed by John and Kirsty. If they're quick questions, I'd be grateful.

11:15

[151] **Elin Jones:** Yes. Can I ask you about the management of the capital budget? You've provided a table for us in your papers on NHS-approved projects? As far as I can see for 2016-17, the total spend allocation there is only around £30 million and your budget, of course, is going to be £237 million. You've said earlier that you'd signed off yesterday local health board capital allocations, so, would I be correct in thinking that that totality then would be the £200 million difference between this table? And why are some of these projects looking as if they're national projects, but they're obviously in local health boards? Then you have local health board projects that don't appear in this table. So, for example, because I've mentioned it in every single budget scrutiny session for the last five years, the Cylch Caron project in Tregaron isn't on this list. Would I assume then that it's in the £200 million that is agreed with local health boards? Is that the way your management of the capital project budget line works? Because it's a bit confusing the way I see it.

[152] **Mark Drakeford:** I'll try and make it a bit clearer, if I can. So, the capital programme that the health Minister will have at her or his disposal next year is about £253 million. That's a result of £33.4 million extra that's been allocated to the portfolio in the draft budget. A large amount of that is taken up before any decisions are made because they are schemes that were approved in previous years. So, the Llandrindod hospital investment, for example, of which there is about just under £2 million being spent in this financial year, will have a carry forward into the next financial year, which is already committed and is already there in the budget. Then, there is discretionary capital, which we give every year directly to health boards, so that eats into it further. Then there is a sum of money to be allocated for new schemes or to enhance schemes that we've made part approvals of so far.

[153] So, to answer Elin's question directly, the advice that I agreed yesterday will show £1.8 million in the next financial year to take forward the Cylch Caron scheme. It will show £3 million specifically in the budget to take forward the Cardigan hospital scheme, and those are new allocations. So, they will appear newly on the list. Schemes that were approved previously and are carrying forward just have been approved already and will appear. But, we will set out all the schemes that will be supported by that capital programme next year, or where we have intentions to do that. So, it's those three components: things that have started already, which is about £100 million carry-forward, discretionary capital that goes directly to the health boards—and my intention next year is to increase discretionary capital by 50 per cent for all the health boards as a recognition of some of the pressures that they are facing in minor repairs and maintenance and replacement of equipment and so on—and then there will be a set of new standing commitments based on plans that are coming through the system, health board priorities and some important national priorities. So, for example, you will see, when it's available, that there is a significant sum of money which I've agreed to set aside for next year, which is about the replacement of major equipment in parts of the Welsh NHS: major scanners that are beyond the capacity of health boards to deal with through discretionary capital, for example.

[154] **David Rees:** Can I just ask a question, Minister? Will you be able to provide us with a breakdown of the allocations of the capital?

[155] **Mark Drakeford:** As soon as we're in a position to make those public, I'll make sure that the committee members get a copy of those.

[156] **David Rees:** Elin.

[157] **Elin Jones:** So, just for me to understand—. That's excellent. I love what you said on Cylch Caron and Cardigan. But just for me to understand, then, in terms of the list you've provided us—

[158] **David Rees:** Annexe D.

[159] **Elin Jones:** Annexe D—that is what you refer to as your national projects that are already committed, with some carry over into 2016?

[160] **Mark Drakeford:** Without annexe D in front of me, I think that would be an accurate description. If nobody has anything else to say, we'll assume that your description is fair.

[161] **Elin Jones:** Okay, we'll take it as that. I'm not going to complain this morning.

[162] **David Rees:** I'm conscious of the time, Minister. Have you got an extra couple of minutes, just for Kirsty and John to ask their questions?

[163] **Mark Drakeford:** Yes.

[164] **David Rees:** John and then Kirsty.

[165] **John Griffiths:** One project that is very, very important across Gwent, of course, is the specialist and critical care centre at Llanfrechfa. I just wondered, on the back of what you just said, Minister, what the position is with regard to that project.

[166] **David Rees:** I'm sure that will be Kirsty's question, as well.

[167] **Kirsty Williams:** Well yes, given that my constituents had to travel all the way down to the Gwent over Christmas, because of the inability to fill the rotas in Abergavenny. Of course, the hospital should've been built by now, so that shouldn't have happened. It would be useful to know when it will happen.

[168] **Mark Drakeford:** The position we're in with the specialist and critical care centre is this: the latest stage in the business process is with us; we

continue to be in discussions with the health board about it, because it's not completely in a position where I can just sign it off. But as a sign of our commitment to that project, and because that's the position I want to be in, you will see a sum of £36 million identified in next year's capital programme to take forward the SCCC. It's the largest single capital investment that we identify for next year and I'm very keen that we are able to release that money to the health board to get on with it. It does mean that we've got to bring that business case discussion to a successful conclusion, but the money is there, earmarked in next year's budget for that to happen.

[169] **David Rees**: Okay. Kirsty.

[170] **Kirsty Williams**: Can I just move on very quickly? Forgive me if it was in your paper and I've missed it. You'll be aware of the decision of the Westminster Government to end student nursing bursaries. What discussions have you had with your colleagues about what the consequences will be? It's a big issue.

[171] **David Rees**: I appreciate that, but I wanted to question—

[172] **Mark Drakeford**: A very quick answer, if I could, then, Chair, which is: you'll know that the Welsh Government has a one-year budget that will affect nurse education from 2016-17 onwards, and I have no plans to change the arrangements in that year.

[173] **Kirsty Williams**: Thank you.

[174] **David Rees**: Alun, on the SCCC.

[175] **Alun Davies**: On the SCCC, yes. I very much welcome the indication that you've just given in answer to a question from John. Can I just understand what you've said there? The business case is with the Welsh Government, you are working with Aneurin Bevan to firm up and complete that business case, but on the basis of achieving that, you're now allocating the funding to enable building to start, so that we're not looking for a final decision now—that's been taken—what we're looking at now is the delivery of that. What you're considering with the health board are issues around delivery, rather than issues of substance and decision.

[176] **Mark Drakeford**: Let me just try and make sure I've said it—. I think that's almost exactly the way I would see it, but just so that I get it

completely right, there is a business case process and, at every stage, in the end, the Welsh Government has to sign off that the business case is fit for purpose. We're not quite at that point with Aneurin Bevan at the latest stage yet, but we are in very direct discussions with them about it, and because it is our shared ambition to get that agreed, I have put into the capital programme next year the sum of money that will be needed, once that agreement is reached. My ambition is to reach agreement and for that money to be spent. The money is there to be spent, provided that agreement can be obtained. But it's got to be a proper agreement; I'm not signing off any business case that isn't fit to be signed off, and I've made that clear to the chair of the local health board. Our aim is to have the discussions to get it agreed so that the money that is now earmarked in next year's capital budget is there to be used.

[177] **Alun Davies**: But you don't foresee any showstoppers in those conversations. And the £36 million, the profile of expenditure, is sufficient to meet the timetable that the health board has outlined. So, the £36 million is profiled expenditure that is designed to meet the existing timetable for that opening.

[178] **Mark Drakeford**: It's profiled expenditure. I just think, I mustn't say anything here that would, you know—. This is something that's got to work properly and that means I've got to be open minded until I get the advice, and I've made clear the advice I hope to see.

[179] **David Rees**: I take it as a position that you've demonstrated your confidence, but you're not going to release that funding until the business case has been approved, but it's a demonstration of your commitment to the case.

[180] Okay. Thank you Minister, and thank you very much for your time this morning; I appreciate we've gone over time. I've got one question, which no-one else has asked. The independent living fund was an allocation from the UK Government, and the Welsh Government committed to allocate that. That happened last June. Do we know where we are for the next 12 months from June onwards?

[181] **Mark Drakeford**: We do, Chair. So, you know that we had £21 million in the current financial year from June onwards, with no guarantee that that money would be made recurrent. Because it was just a nine-month sum of money, we agreed a way of distributing it, which is that we have used our

local government colleagues—I'm very grateful to them, because I think they've done a very good job—to hand the money on to the people who are the recipients of it, and I think they've done that very successfully.

[182] In the comprehensive spending review, £27 million—which is the full-year effect—was confirmed in our budget for next year, and I intend to allocate the full £27 million to the independent living grant, as it's now called, in Wales. I don't intend to change the method of administration for next year, because it's worked well in the short run. I recognise that, in the longer run, we probably will need to make some adjustments to that, and my officials are having discussions, both with local government colleagues and with organisations that represent recipients of the independent living fund, to come to some decisions about the long-term arrangements in Wales.

[183] **David Rees**: And can I confirm that's not anything to do with the increase in funding to local government for social services?

[184] **Mark Drakeford**: The £27 million for the independent living fund is completely separate to the £21 million extra investment in social services in the revenue support grant.

[185] **David Rees**: Okay, thank you very much, Minister. May I thank you and the Deputy Minister and your officials this morning for the evidence you've given us? It's been very helpful for us. Obviously, if there are any matters we haven't reached, we may well write to you for clarification on that. So, once again, thank you very much for your time.

11:27

Papurau i'w Nodi
Papers to Note

[186] **David Rees**: If we can move on to item 4, we've got some papers to note. Are Members happy to note the minutes of the meeting held on 3 December 2015? And the correspondence between the Minister for Health and Social Services and the Children, Young People and Education Committee regarding child contact centres in Wales. Thank you for that. And just to note publicly that, clearly, we also had in our evidence the letter from the Minister, regarding the funding allocation, to the Children, Young People and Education Committee. That was in our papers for evidence.

Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod hwn ac ar gyfer Eitem 1 y Cyfarfod ar 20 Ionawr 2016

Motion under Standing Order 17.42(vi) and (ix) to Resolve to Exclude the Public from the Remainder of this Meeting and for Item 1 of the Meeting on 20 January 2016

Cynnig:	*Motion:*
bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac ar gyfer eitem 1 o'r cyfarfod ar 20 Ionawr 2016 yn unol â Rheol Sefydlog 17.42(vi) ac (ix).	*that the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 20 January 2016 in accordance with Standing Order 17.42(vi) and (ix).*

Cynigiwyd y cynnig.
Motion moved.

[187] **David Rees:** Item 5, therefore. Can we now propose, in accordance with Standing Order 17.42(vi) and (ix) that we resolve to meet in private for the remainder of this meeting and for item 1 of the meeting on 20 January 2016? Are Members content with that? Okay, thank you. Then we now move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:28.
The public part of the meeting ended at 11:28.