



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Mercher, 9 Hydref 2013
Wednesday, 9 October 2013

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynndi 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

Leighton Andrews	Llafur Labour
Rebecca Evans	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
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	Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol Minister for Health and Social Services
Kevin Flynn	Cyfarwyddwr Cyflenwi a Dirprwy Brif Weithredwr GIG Cymru Director Delivery & Deputy Chief Executive of NHS Wales
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol Cymru Director of Social Services Wales
Dr Grant Robinson	Arweinydd Clinigol ar gyfer Gofal Heb ei Drefnu Clinical Lead for Unscheduled Care
Gwenda Thomas	Y Dirprwy Weinidog Gwasanaethau Cymdeithasol Deputy Minister for Social Services

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

Sarah Hatherley	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 09:05.
The meeting began at 09:05.

**Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions**

[1] **David Rees:** Welcome to the committee. The meeting will be bilingual and headphones can be used for simultaneous translation from Welsh to English on channel 1, or for amplification on channel 0. I remind everyone to turn their mobile phones off, or other electronic equipment that may interfere with the broadcasting equipment. In the event of a fire alarm, as there is no scheduled fire drill, please follow the ushers. We have not received any apologies this morning.

09:05

**Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru): Cyfnod 2—Trefn y
Drafodaeth
Social Services and Well-being (Wales) Bill: Stage 2—Order of Consideration**

[2] **David Rees:** You have all received the paper presented by the clerk in relation to the order of consideration, which was discussed and agreed last week. Are you happy to ratify the consideration order that was recommended? I see that you are. Thank you very much. I also remind you that, following yesterday's debate and vote, which approved the general principles of the Bill, Stage 2 has now commenced. Therefore, amendments can now be submitted, and the deadline for amendments is 4 November for Government amendments and 6 November for other amendments. That is dependent upon the order of consideration, and whether we are able to complete sections at different times during the process. So, there may be opportunities for some amendments to come in later.

09:06

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

[3] **David Rees:** I move that

the committee resolves to exclude the public to discuss items 4 and 7 of the meeting in accordance with Standing Order 17.42(vi).

[4] Are all Members happy with that? I see that there are no objections. We will reconvene for the public at 10 a.m. for the ministerial scrutiny session on unscheduled care in preparedness for this coming winter.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 09:07.
The public part of the meeting ended at 09:07.*

*Ailymgynullodd y pwyllgor yn gyhoeddus am 10:04.
The committee reconvened in public at 10:04.*

Gofal heb ei Drefnu—Bod yn Barod ar gyfer Gaeaf 2013-14
Unscheduled Care—Preparedness for Winter 2013-14

[5] **David Rees:** Good morning and welcome back to the public session of this morning's meeting of the Health and Social Care Committee. This session gives an opportunity for ministerial scrutiny on unscheduled care. I welcome the Minister for Health and Social Services, Mark Drakeford; the Deputy Minister for Social Services, Gwenda Thomas; Albert Heaney, director of social services; Kevin Flynn, director of delivery and deputy chief executive of NHS Wales; and Dr Grant Robinson, who was appointed as clinical lead for unscheduled care. Good morning and welcome to this morning's session. Minister, you made a statement in April on unscheduled care, and we have invited you to prepare us for the winter ahead. Would you like to make some opening remarks?

[6] **Mark Drakeford:** Diolch yn fawr, **Mark Drakeford:** Thank you, Chair, and Gadeirydd, a diolch am y cyfle i fod yma y thank you for the opportunity to be here this bore yma i roi tystiolaeth i'r pwyllgor. morning to give evidence to the committee.

[7] Thank you for the chance to provide some evidence to the committee this morning about the preparedness of the NHS in Wales and its partners for the coming winter. As Members here will be aware, last winter was the hardest, the longest and the coldest for half a century, with no other winter like it for more than half a century before that. Public Health Wales has carried out an analysis of the pressures that the health service came under during last winter, and it suggests that, even if this winter is less severe, there will still be a set of underlying issues that will make the coming season a hard one as well. Among the reasons that we know will be there, even if the winter is milder, is that there is an underlying pattern of growth for attendances at accident and emergency departments, and that growth is particularly steep in relation to the attendance of people who are aged 85 and above. In the Public Health Wales analysis, it believes that if you isolate all the different reasons that created pressure last winter, the single most significant one was the impact of poverty and the fact that, in many communities, the issues of fuel poverty and reduced benefits mean that people's likelihood to end up in poor health and be admitted through an emergency department was increased. So, against that background, the coming winter is going to be a challenging one.

[8] Planning for next winter began in the Welsh Government back in March, while there was still snow on the ground, and planning has gone on at both national and local health board level ever since. We can provide some further details of that to you during the session, if Members would be interested in it.

[9] I do not think that anyone could be anything other than struck by the resilience that the NHS has shown in recovering from last winter. In April, 85% of patients were seen within four hours at Welsh A&E departments, and the figure has been above 90% ever since. Some 57% of ambulances responded to category A calls in eight minutes back in April, and the figure in September was 62.9%, the highest level for more than 12 months. In fact, the number of people conveyed to an accident and emergency department in September within eight minutes was higher than the last time we hit the 65% figure, because of the fact that more people are calling ambulances than ever before.

[10] The upshot of all of this is that while the months ahead will be hard, and that, at times, the pressure will undoubtedly be felt in the system here in Wales, the NHS begins the coming winter in a better place than it was in this time last year, in terms of both planning and performance. Members here will be well aware that the NHS is only one part of the unscheduled care picture, and Gwenda Thomas, as the Deputy Minister, is going to say a few words now, if that is acceptable, about the interface between health and social care and the

work that has gone on there over recent months.

[11] **The Deputy Minister for Social Services (Gwenda Thomas):** On 19 July, I published, jointly with the Minister, outline plans to bring about greater integration of health and social services for older people with complex needs. Older people with these complex needs are a key priority, and we have developed an integration framework, which you all know about, and that is out for consultation at the moment until the end of October. We will ensure that actions are taken forward in the short and medium terms to improve services for this group of people. The framework contains guidelines and timelines that we believe can deliver more integrated services.

[12] Health boards, local government, the third sector and other partners have been tasked with a range of actions to improve the planning, co-ordination and delivery of services, as well as care and support, to meet the needs of people in their local areas. The Minister and I, along with the Minister for Local Government and Government Business, have also been meeting with health boards and local government colleagues to discuss how they will take forward the work in relation to the integration of services across health and social care. There are, of course, some good examples that we all know about. I will not mention them all, but you know about the Wyn campaign, the virtual ward in Carmarthenshire and the Gwent frailty project—I could not omit that one because we have become very familiar with it.

[13] However, more recently, and during these meetings, we heard about Bridgend and the fact that staff from health and social services are working together to provide intermediate care services, which are accessed via a single point of contact, the community resource team, which provides a six-week assessment pathway, focused on the needs of the individual. This includes rapid response, intermediate care, beds and domiciliary rehabilitation. We were very interested to hear about that development. In Neath Port Talbot, there is a blended care package, which provides a person-centred approach across health and social care so that the needs of the individual are dealt with in one visit rather than multiple visits by different professionals. Yesterday, of course, there was the announcement, which I am sure that we were all pleased to hear about, in relation to the additional funding of £50 million for 2014-15 to create the intermediate care fund. The proportion of that that goes into the local government main expenditure group—because it will be paid through local government—is £35 million; and there will be £15 million capital through the housing and regeneration MEG. Of course, we will be working very hard and collaboratively to ensure that that is used for the integration of health, housing and social services so that we better support independent living within our communities.

[14] **David Rees:** Thank you both for your opening remarks. Minister, we are obviously interested in the plans, and if they do not come up during the questioning I will give you some time at the end of this session to discuss them as you wish. We have questions from Darren, Gwyn, Kirsty and Rebecca. I call on Darren first.

[15] **Darren Millar:** Thank you, Chair; and thank you, Minister and Deputy Minister for your opening remarks. One thing that neither of you referred to was the additional resource that was announced yesterday for the NHS in this current financial year, namely the £150 million that I am delighted to see going into our national health service. To what extent will that be used to address winter pressures over these next few months?

[16] **Mark Drakeford:** Thank you for that question. As Members here will be aware, the current financial year is a challenging one for the national health service. All health boards have plans to live within the budgets available to them, and some of those plans show a gap between what health boards have and what they need. So, it will be my job over the next few days to work on the distribution of the extra funding that the Minister for Finance has made available as a result of the review that we undertook during the summer. Undoubtedly, the

allocations that LHBs will have will allow them to strengthen the services that they plan to provide over the winter compared with the services that they would have been able to provide had that extra funding not been made available to them. I do not intend to hypothecate the money to health boards for particular purposes because there are challenges across the whole system, whether it is in elective or planned care, in primary care or in emergency departments. The general point that Darren has made, which is that the extra money will allow LHBs to come through the winter in a better way than they would have without it, is certainly well made.

[17] **Darren Millar:** Where was the £150 million from? Did it come from within the social services budget, or was it from another part of the Government's budget?

[18] **Mark Drakeford:** The money is additional to both the health and the social care budgets. It does not come from within our own budget. It has come through the work of the Minister for Finance with other Cabinet colleagues to release money from other parts of the Welsh Government so that the health budget has that as additional funding.

[19] **David Rees:** Minister, you mentioned that you will be discussing this over the next couple of days, and you will be appearing before this committee next week to discuss the budget, therefore will you be in a position then to clarify a few further details?

[20] **Mark Drakeford:** I hope to be able to do that then.

[21] **Darren Millar:** The budget, of course, will look at next year's allocation rather than this year's.

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

10:15

[23] **Darren Millar:** I wish to ask about the distribution. You said that you had not yet decided on how you would distribute the extra resource yet. There has been some criticism from the Wales Audit Office in previous years about the way in which the resource had been allocated, in that it was not perhaps scientific enough and did not recognise the pressures in different parts of Wales. Given that the biggest pressure appears to be the demographics across the country, will you be looking at a formula that allows recognition of the demographics and the potential pressures on unscheduled care in particular across Wales through the distribution decision that you make?

[24] **Mark Drakeford:** I am definitely attracted to allocating the money by means of a formula, rather than looking at where the biggest holes are to fill and putting the greatest resource there. However, I will have to look at a range of possibilities. The £10 million that we were able to announce just before the summer for extra nurses in the health service was allocated on a formula basis and was a combination of population and Townsend shares. So, there was a formula—it applied to everybody and everybody got their share based on the formula. I do not yet have concluded advice on what sort of formula we will use for the £150 million, but I definitely want a system that allows everybody to see the basis on which money ends up where it ends up.

[25] **Darren Millar:** I will ask one final question on this. Obviously, most people will regard this additional resource as yet another bail-out for the NHS, in-year, which was not planned. The message at the start of the year was, 'You're not going to get any extra cash', and yet here is another lump sum announced yesterday, unusually on the same day as the budget. There has been brokerage in the past; is this brokerage, or is it just a bail-out?

[26] **Mark Drakeford:** It is neither.

[27] **Darren Millar:** I did not think you could do either of those.

[28] **Mark Drakeford:** It is not brokerage. It is the product of the work that went on over the summer in relation to the Francis review. I announced that with the Minister for Finance before we broke up in the summer. The Francis agenda creates a whole new series of challenges that the health service has to face up to, and those challenges come with costs. Those challenges include staffing on wards, which we have talked about before, and we in Wales are very keen again to have a formula on that. The chief nursing officer has already devised one in relation to medical and surgical wards, so that we know how many nurses we need at any one time, but if we do not have sufficient numbers there now, those nurses will cost money. There are other Francis-type costs that we worked on over the summer and the sum of money that we have available this in-year for the health service is neither a bail-out nor brokerage; it is a recognition of the extra challenges that the health service faces today that were unforeseeable when the budget was originally set out.

[29] **Gwyn R. Price:** Good morning, everybody. On the flu vaccination preparation, could you bring us up to date on any ongoing campaigns, and could you just clarify the issue of the nasal spray vaccine? It says here that GPs can give it to healthy children aged two and three, and 11 and 12-year-olds would have it in school. Obviously, there is a gap there, so could you clarify in relation to that?

[30] **Mark Drakeford:** I will probably turn to my colleagues for some of the more specific advice. In general, we are very determined to have an active flu campaign during this winter. It has already begun and it has a series of component parts to it. We are learning from what we think was effective last year in the way that money was spent to publicise the flu campaign. We are making greater use of community pharmacies this year than we were able to last year. I know that members of the committee have been very keen on the use that can be made of community pharmacies to deliver flu vaccinations. A start was made on that last year; we are doing it in a much larger and easier to understand way this year. I will be in Swansea tomorrow to publicise a whole week of winter preparation campaigns that are going on at community pharmacies and with Public Health Wales and Age Concern.

[31] I particularly wanted to concentrate on an issue that came up when I was before this committee on the measles outbreak before the summer, when Leighton asked me about the obligations in relation to staff in the system having to be vaccinated against preventable diseases. My particular interest this winter has been on trying to do everything we can to make sure that staff in the NHS and in the social care system take a flu vaccine, so that they do not pass flu on to their own patients or that they do not fall ill with flu when they need not. We are stepping up the messages that we send out. The chief nursing officer wrote last week to all nurses and midwives in Wales making it clear that, as far as she was concerned, it is part of their professional obligation to take advantage of something that is free to them. We pay for it and it ought to be part of their obligation. Where people choose not to do so, particularly if they choose not to do so in a way that prevents other people from becoming vaccinated, because there are some instances of that, then we will take it up through the professional machinery. It is a serious matter and needs to be taken seriously.

[32] The nasal spray is being offered to small children in GP surgeries; we will find out about school-based opportunities in a moment. Given that this is one of the new vaccines that has been introduced this year for that age group, there will be a period of time in which we have to build up the vaccination of children in that middle part of the age range, because we simply do not have either enough of the vaccine—manufacturers cannot manufacture it fast enough to be able to offer it to the whole of the age range—or the infrastructure to be able to do it. I will ask Dr Grant Robinson to come in here. Members will know that in the statement

that I made before Easter I said that I was keen to appoint a national clinical lead for unscheduled care in Wales. I was pleased that we had a very high level of interest in that post, with some very senior applicants for it. We are particularly pleased that we have been able to appoint to Dr Robinson to undertake that job over the coming winter. Grant, I will ask you to continue.

[33] **Dr Robinson:** I wanted to say something about the vaccination of staff. However, on the specific question that you asked about school vaccination, the answer is ‘I don’t know’. I am not sure whether Kevin knows, but we can certainly go away after this meeting and provide that information to the committee, because it is an important point. I know from conversations that I have had with public health colleagues that they are particularly keen to ensure good coverage of children, because, of course, not only can flu make children unwell, but, more importantly, they can be responsible, unwittingly as vectors, for spreading the disease. We absolutely do not want to be in a position where we have to make people, particularly older people, think about whether they should be looking after or interacting with children. There are ways to avoid that. On the specific point that you raised, I do not know and we will find out for you.

[34] **Gwyn R. Price:** If you could do that it would be helpful, because we will have people with four and five-year-olds coming up to us and asking, ‘Why is the nasal spray available for a three-year-old but my child can’t have it?’ So, I would be interested in having that information.

[35] **Dr Robinson:** We can clarify that. Chair, the point about professional priorities is important. It has been the subject of conversations between me and the British Medical Association since I came into this role. I am pleased to say that there is strong support from the British Medical Association to promote flu vaccinations among staff members. There are some staff members who have been reluctant to have the vaccination—not just doctors and nurses. However, there is a growing sense that it is a professional priority and people are increasingly showing leadership on this. I had my flu vaccination this week. We are encouraging people to have it, to talk about having it and to make sure that as many members of staff as possible are vaccinated so that we keep them in work and reduce the risk that they will pass on this disease, which can be lethal to older people.

[36] **David Rees:** I now have three individuals who wish to ask supplementary questions on this issue. Rebecca, you can go first, then Lindsay and Darren.

[37] **Rebecca Evans:** You are very clear that being vaccinated against the flu is a professional obligation and you talked about the responsibility on the individual to be vaccinated. Do you see that there is a responsibility on health boards to ensure that their staff are vaccinated, and would you consider making funding dependent on reaching a certain threshold of vaccination among their staff? I know that they have done that in England, in that access to the new £500 million accident and emergency fund is dependent on a 75% threshold.

[38] **Mark Drakeford:** I do not think that you can make local health boards require people to be vaccinated. We have not got to that point. What local health boards have to do is to make sure that it is as easy as possible for any member of staff to be vaccinated. We provide funds to them so that they are able to offer that service for free. More has been done this year, through occupational health and other ways that health boards have of making it as easy as it possibly can be for their staff to be vaccinated. We have not decided to tie funding to any particular levels.

[39] **Rebecca Evans:** With regard to the nasal spray vaccine for two and three-year-olds, how and when will parents know that they can access it? It is new, so a lot of people will not

have heard of it yet. Are you going to require GPs to be quite proactive in promoting it?

[40] **Mark Drakeford:** Yes, it is through the GP that it is being done. There is a high level of activity at GP surgeries in terms of the flu vaccines and other new vaccinations that have become available this autumn, such as the shingles vaccine. GPs have been involved in a big campaign around vaccination, and the availability of the nasal spray—which is not just easier but is a great deal more effective than the injected form of vaccine—has been prominently pursued by them.

[41] **Lindsay Whittle:** I am so pleased, Minister, that you have not followed your English counterpart, Jeremy Hunt, in tying that in to funding. I certainly do not want to live in a culture and country of blackmail, especially where £500 million for A&E funding was available. I think that the statement that you just made was extremely positive. NHS staff are very important, but what about local authority staff—carers going from house to house? Do you think that we should be including those as well?

[42] **Mark Drakeford:** The approach that we have taken in Wales is that it is the responsibility of employers to make sure that vaccination is available to their staff. Many local authorities, which directly employ social work staff, for example, who are involved in going to people's homes, do exactly that. We are doing more this year with the care home sector, and the domiciliary care home sector particularly. The discussion that we are having with them is more about business continuity. Why should a domiciliary care company pay for its staff to have a vaccination? We have not been approaching it on the basis that it is good for the staff and that it means that they will not be spreading flu and everything like that. We are saying to them that they have a business to run and they need that business to run right through the winter, when people are most vulnerable to flu. They do not want their business to be let down by the fact that their staff are suffering from an avoidable illness, so it is in their business interests to offer people free vaccinations. There are examples—not as many as we would like, and not as widespread as we need them to be—of care companies taking advantage of the fact that community pharmacies are able to offer vaccines and doing a deal with them. In that way, they are able to purchase flu vaccines for staff at a very much reduced rate, so that they get business continuity in a financially efficient way as well as the service itself being able to continue.

[43] **Lindsay Whittle:** That is a far better approach.

[44] **Darren Millar:** I was going to ask precisely that question about private enterprises and what you are doing to encourage them to take up the vaccine. Another question that I had in mind was this: do you have a target to measure against in terms of the percentage of the workforce in the NHS that has direct contact with patients that you want to see vaccinated, and also with the social care workforce?

[45] **Mark Drakeford:** We do. We have a 50% target for this year.

[46] **Darren Millar:** That is not very ambitious.

[47] **Mark Drakeford:** It is not as ambitious as I would like, but it is set against the fact that, last year, we achieved a 35% level. However, that was a considerable increase over the low 20% level that was achieved the year before. The graph is moving upwards quite sharply, but to get to 50% from 35% will be a big extra leap, and we will set another challenging target—hopefully more so—for the following year.

10:30

[48] **Darren Millar:** Have you been able to identify a correlation between flu vaccination

and sickness rates in those local health boards that have higher take-up rates, for example?

[49] **Mark Drakeford:** I do not have those figures, but I am sure—

[50] **Dr Robinson:** I have seen the uptake rates for last year and there are not big differences between health boards in Wales—some are a little better than others, but there are not huge differences. So, it would be difficult to do it in Wales. I know that, wider than Wales, some organisations have achieved much higher uptake rates, but I am not aware of data that correlate that to time off. Anecdotally, I have been told by medical directors in organisations that had high rates that they thought they were seeing lower rates of sickness among staff. I would certainly feel much more comfortable—I was previously a medical director working in such an organisation—with higher uptake rates, because you then relax a bit about transmission to the patients as well.

[51] **David Rees:** We have two other people who want to comment on this, but I will come back to those, because we need to move on a little.

[52] **Kirsty Williams:** Minister, my understanding is that the individual plans for LHBs are currently not available. Your paper suggests that they will be given to committee members shortly. Could you tell us when the individual local health board plans will be in the public domain?

[53] Your paper talks about the constraints on bed capacity and it is simply impossible to continue increasing the number of beds available, but could you tell us how many beds will be available to open to meet demand? Last year, 2,600 operations were cancelled because of a lack of beds. Could you tell us what your anticipation is this year in the number of elective operations that will be lost, as a result of winter pressures?

[54] Dr Robinson, I am wondering whether, since your appointment, you have had any discussions with GPs and out-of-hours services, because, of course, they are crucial in managing capacity. If they simply decide to send everybody to the A&E department, then we have a problem on our hands. I am wondering whether there are any plans within GPs and out-of-hours services to increase the services that they have available over the winter.

[55] Finally, it is almost six months, Minister, since you made your statement about reducing the number of delayed transfers of care, setting out a whole list of work programmes and initiatives. What are the outputs and outcomes, six months down the line? Our figures show that, this August, there is deterioration in performance, as compared to last August. So, in terms of preparedness for this winter, we seem to have more people languishing in hospitals and we seem to be slower at getting them out of hospitals in anticipation of the winter than we were last August.

[56] **David Rees:** There were three questions there, Minister—

[57] **Mark Drakeford:** I think that I have five written down. [*Laughter.*]

[58] **David Rees:** I missed a couple. If you could take the issue of beds and delayed transfers first.

[59] **Kirsty Williams:** Well, we have spent half an hour talking about the flu vaccine.

[60] **Mark Drakeford:** In relation to unscheduled care plans, I expect LHBs to publish those and I expect them to be available on their websites. We will alert Assembly Members. They should be available now. They should be taken through their boards and be public documents, because these documents were drawn up earlier in the year. There are to be

formal winter plans, which is the winter-specific application of the unscheduled care plans. At the moment, those are being commented on by Welsh Government, but they ought to be concluded within the next month or so, and they ought to be public, too. However, the unscheduled care plans are already done and ought to be available through LHBs. I will remind them that I expect those documents to be public and to be available, and we will alert Members to that.

[61] In terms of beds, the plans that LHBs have declared to us for the winter show around 460 beds as surge capacity—beds that they do not have now, but that they will be able to open if they need to do so. I entirely agree with what Kirsty said that beds are not the answer by themselves, but we can talk about the part that they have to play.

[62] Grant can take up the point about GPs. However, on delayed transfers of care, I thought that Kirsty was half right: the numbers of people showed as delayed in August are higher, but the median length of stay this August is lower than last year. The number of days that are lost is lower. There are more people waiting, but they are waiting shorter periods, so more beds are becoming available. The one category that is down this August is ‘choice’, so, we are having some impact.

[63] Gwenda will probably tell you what meetings we have been having with all local authorities where the theme of choice is still coming through very strongly, but there is a bearing down on choice and I am very determined to do more on that, if we can. There are almost no delays anywhere in Wales now where people are sitting in a hospital bed waiting for a dispute between a local authority and a local health board to be resolved. I want that figure to be zero. However, some of the problems lie in those things that are outside the hands of both Welsh Government and local authorities. In the Gwent area, in the last few months, 160 beds have been lost in the nursing home and high-end residential care sector, where some big suppliers have announced that they are closing homes. When you suddenly need to find 160 places and you are trying to find places for people who are in hospital, there is an inevitable interplay between those two. I think that Dr Robinson wants to say something on GPs.

[64] **Dr Robinson:** Yes, I am happy to talk about GPs. The answer to the question as to whether I have been talking to GPs, and whether the GP out-of-hours service is an important part of the work around unscheduled care, is ‘yes’. We are in the early phases of my involvement here to organise a programme of improvement for unscheduled care, and one of the work streams will be for primary care, out-of-hours services and unscheduled care. So, that is certainly on the agenda.

[65] It is important that I point out in a forum like this that it is not my belief that the problems that we have in A&E departments are because of a failure of GPs or a failure of the out-of-hours service. However, there is no doubt that the out-of-hours service is under considerable pressure and needs to be refreshed; that is recognised. I will be working as part of this to look at the best way to do that in the future. There are also important opportunities for GPs to work differently, both in their in-hours service and in the out-of-hours service, to work in a more seamless way with hospitals. GPs are asking for that as well as hospitals. That involves a conversation—the kind of conversation that I think it is my job to facilitate—between clinicians working in primary care and in hospitals. Some of those conversations, of course, are already taking place—it is not as if I am inventing the wheel here. However, I think that there is a job to do to make that more consistent and to spread the best practice. Gwenda has already said that there are some great examples of really good practice around Wales, and we want to make sure that they are everywhere in the future. However, I would recognise that there are weaknesses around existing out-of-hours provision—which are not unique to Wales, by the way—that we need to fold into this work as we move forward.

[66] **Kirsty Williams:** Could you outline what those weaknesses are?

[67] **Dr Robinson:** The existing services sometimes have trouble manning ahead of time, so that they wait until quite close, particularly to holiday periods, to figure out who will be providing the service. Putting those services on a more predictable and consistent footing, so that there is no possibility of leakage of work into very busy casualty departments, is important. There have been occasions when out-of-hours services have not been in operation where they needed to be. That is the kind of pressure that our A&E departments can do without.

[68] **David Rees:** Would you like to comment further on that, Deputy Minister?

[69] **Gwenda Thomas:** Yes, just to mention that the integrated task and finish group is developing measures to try to ensure that delayed transfers of care are reduced, and also to mention the statutory integrated assessment and care framework that we will have in place by December. I think that that is really important. It is aimed at rapid assessment, more consistency of care needs, and to ensure that the appropriate support is available when people need it. So, I think that that is very positive work. Of course, the push towards integration through the framework, after the consultation, will give it strength and more purpose and it will achieve, I hope, more consistency throughout Wales, in that the framework will be an all-Wales framework to achieve that.

[70] **Kirsty Williams:** On a recent visit to a district general hospital to look at how it managed unscheduled care, the staff said that they groan when they see certain GPs' signatures on the forms. There is anecdotal evidence to suggest that there are some GPs who are willing to manage risk in the community more readily than, perhaps, other individual practitioners. I am just wondering what we can do to reassure those particular practitioners, to support them in managing risk and to give them other options, rather than a referral to a DGH.

[71] **Dr Robinson:** There are two bits to that question, really. First, about variation in practice between GPs, some GPs are better than others. GPs are human beings, and some of them are better than others. Finding ways to support people and to feed back their information is an active part of the work of the setting-the-direction groups of GPs that have been established in all health board areas in Wales. Again, there is some variation in that work, and we will be interested in looking at where there is good practice. Certainly, in areas where there has been an effective way of feeding back that information, I am aware that there have been significant improvements, particularly with GPs who were struggling a bit. Sometimes, it was not their fault; sometimes, they needed support.

[72] To deal with the second part of your question, the routes into advice from hospital specialists are sometimes not as clear as they can be. So, again, some of the best conversations go on where GPs get together with their secondary care counterparts and say, 'Well, how can we have a quick conversation to avoid an unnecessary admission if a patient can be dealt with the next day in a hot-clinic or through a conversation, where you tell me what we need to do next to keep our patients safe rather than sending them into hospital?' There are certainly opportunities in that area to spread best practice and to make sure that everyone is adopting that approach, because there is no doubt that—again, this is not a Welsh problem; this is a problem across unscheduled care in developed countries—there are opportunities to manage patients differently and, generally speaking, patients prefer that approach as well. They would prefer not to be in hospital if it can be avoided.

[73] **David Rees:** Okay, I am aware that several Members have questions, and we have limited time. Lynne has a supplementary question on this point.

[74] **Lynne Neagle:** Yes, I have two supplementary questions. You rightly highlighted the

pressures in Gwent at the moment as a result of the loss of the nursing home beds and, as we know, Gwent has been a hotspot for difficulties with unscheduled care, with problems at the Royal Gwent. Is the Welsh Government taking any particular steps to focus on the problems arising as a result of the loss of those nursing home beds? I also want to follow up on something else that Kirsty said about elective capacity. Obviously, we saw a lot of elective operations cancelled last year. Are there any plans to protect elective capacity in the coming winter?

[75] **Mark Drakeford:** In terms of what we are doing in Gwent—

[76] **Gwenda Thomas:** Yes, the—

[77] **Mark Drakeford:** Cer di.

Mark Drakeford: You take that one.

[78] **Gwenda Thomas:** I am aware of the concerns that you have raised about St Dunstan's and the other home in Gwent. The issue here, I think, is what authority we have to try to ensure the financial viability of providers. You will know from the White Paper that I published last week on registration and inspection that we are looking to establish powers to ensure that providers provide an annual report that will require them to refer to their financial viability. These are the lessons that we learned from Southern Cross, are they not? There will also be a responsibility on registration and inspection regimes to take a Wales-wide view of the financial viability of provision. It is an issue. When things happen, like they have in Gwent, and you lose a lot of beds very quickly, then the interests of those residents must be paramount and alternative places must be found for those residents, and that is not always easy. I know that there are still about 11 people left in one of the homes in Gwent for whom alternative placements have not been found. Care and Social Services Inspectorate Wales is working closely with them. I think that to be able to manage and understand the market is exceedingly important, and that is one of the main aims of the White Paper on registration and inspection.

[79] **David Rees:** Minister, will you answer on elective care?

[80] **Mark Drakeford:** We expect local health boards to manage both unscheduled care and elective demands, and to have the capacity to do both. As part of their planning for the winter, a number of health boards have put in extra beds to protect planned surgery. We have plans from them all that show that they have, over the summer, been recovering from some of the problems of the last winter, when operations were postponed, so they have had a backlog, which they have been tackling.

10:45

[81] Their plans show that, from September, they will be making inroads into the longer waits, and the figures from September show that they have turned the corner and started to do that. Where there are very particular problems that we need to solve, we will take other sorts of action, including, if we need to, offering people operations outside the main Welsh NHS to make sure that elective operations are not postponed in the way that they were.

[82] **Gwyn R. Price:** To go back to the nasal spray, is this nasal spray available over the counter? If it is more effective and if people can go and get it for themselves, is it available over the counter, or is it just something that you are introducing?

[83] **Dr Robinson:** No, it is not an over-the-counter medicine.

[84] **David Rees:** Could I remind Members to keep their supplementary questions to the topic of the current question?

[85] **Kirsty Williams:** The Minister has just said something very significant about a second-offer scheme. We have not had a second-offer scheme for quite a while, and I am just wondering where the second offer would be offered.

[86] **Mark Drakeford:** It is not a second-offer scheme in the way that we had it at one time. As I said, it is confined to very particular issues where we know that we are unable to increase the capacity within the Welsh NHS in the short term in order to clear some backlogs, and it will be negotiated on a clinician-and-individual-patient basis.

[87] **David Rees:** I will allow Kirsty to come back if we have time afterwards. I have questions from William, Leighton, Elin and Lynne.

[88] **William Graham:** Obviously, you will be well aware that the Wales Audit Office in its report on the workforce arrangements said that no A&E department in Wales is able to meet the College of Emergency Medicine standards for consultant presence. In the light of the pressures anticipated this winter, how about recruitment to emergency medicine? Has that been a priority? What costs are associated with that?

[89] **Mark Drakeford:** As Members will know, recruitment into the Welsh NHS is not a problem in the round. We have a smaller level of vacancies than we have ever had in the Welsh NHS. However, there are a small number of specialities where there are difficulties in recruiting, and emergency medicine is one of them. We share that difficulty with the rest of the United Kingdom. We do have more consultants in emergency medicine in the Welsh NHS today than we have had previously, but we still struggle to get to the levels that the royal college, for example, would suggest.

[90] What we have to do is have a different approach, and among the most impressive people who I have seen—and I have been to almost every A&E department in Wales by now—are the advanced nurse practitioners who you see working in emergency medicine and who are trained up particularly for that purpose. They work, then, under the supervision of a consultant, and that is very important, that they have that consultant backup available to them there and then. They are then able to work right up to the top of their licence, which is what we need to expect people to do. People need to be able to do everything that they are clinically competent to do, and that does not simply stop at nurses, but also includes—in a discussion I know we have had here previously—paramedics, for example, who need to be able to exercise the full range of clinical competencies that they have and make decisions where they are competent to do that. We are not going to solve the problem of recruitment simply by trying to get more consultants, because they are in such short supply; we need a wider range of people working under their supervision, and I can give some very successful examples in Wales where we have been able to do that.

[91] **William Graham:** So, would you support, as it were, further specialisation, where the skills base of some of those people is particularly directed at older people?

[92] **Mark Drakeford:** I would probably put it slightly differently. What we actually need are some generalists at the front door of our hospital, who are generalists while being specialists in the care of older people, but who are not specialists in just one slice of what an older person might need so that older people get passed from one tiny fragment of the health service to another. We need people who are specialists in the sense that they understand the needs of older people but are able to respond to those needs across the whole person, rather than in a sort of salami-slicing of medical speciality.

[93] **Leighton Andrews:** I have one question on patient flow and one on workforce arrangements. For the record, I will say that I have had my flu vaccination.

[94] **Mark Drakeford:** Well done.

[95] **Leighton Andrews:** On patient flow, this may sound like a contradiction in terms, but to what extent is it possible to model unscheduled care? I was interested in what you said about the Public Health Wales assessment of the link to poverty, including fuel poverty, but there is also evidence that a surprisingly large number of people with long-term chronic conditions actually have need of unscheduled care, which suggests that some of it might be down to poor condition management.

[96] **Mark Drakeford:** To take the last point first, one of the pieces of better news in unscheduled care is that emergency admissions and readmissions for chronic conditions in Wales have fallen in almost every one of the last 30 months. So, for the last two and a half years, we have reduced the number of emergency admissions for chronic conditions, and they are substantially down on where they were two and a half years ago. That suggests that the answer to your first question is, yes, if you are able to manage the system better and get a handle on the whole system, you are able to have an impact on flow. We have been working with the Health Foundation, because it carried out some important work in Sheffield and in south Warwickshire over the past year exactly looking at unscheduled care and patient flow. It has a model and a programme that it says, if you can apply it, does exactly what we want it to do to free the system up so that there is a flow through A&E into the hospital itself and out of hospital at the end. Through the 1000 Lives Plus programme, we are working with the Health Foundation to try to make sure that we learn those lessons on the flow specifically here in Wales. That is a programme that we shall be working on actively during the winter.

[97] **Leighton Andrews:** Okay. My workforce question really follows up what Kirsty was asking about, in that the suspicion that certain GPs' practices may be less good at managing flow into A&E and may be more risk averse, et cetera. Dr Robinson talked about ensuring support for GP services. What I want to know is whether LHBs have sufficient levers to take action where necessary.

[98] **Mark Drakeford:** The main lever that the LHB has is the QOF—the quality and outcomes framework—and GPs are of course paid depending on whether they fulfil the QOF. So, there are two specific elements in the QOF that relate to this part of a GP's work. They are paid to identify the top 5% of their patient population most at risk of emergency admission to hospital, and to identify them separately on a register. They are then asked to identify the 10% of the 5% who are at the very top end of risk and to have in place an individual, multi-agency plan for dealing with those people. If they do not have it, they do not get paid for it. So, there is, in a sense, a lever there. Whether they have sufficient levers is, I think, a more open question.

[99] **Leighton Andrews:** Do we have much evidence of LHBs refusing payments under QOF on that basis?

[100] **Mark Drakeford:** Yes, we do. We publish an annual report on all the QOF points, and we can tell you at individual practice level which ones received the points and therefore got the money against all those involved.

[101] **Leighton Andrews:** Is that information publicly available?

[102] **Mark Drakeford:** Yes. Last year's was published during the summer, probably when people were away.

[103] **Leighton Andrews:** So, if I were to ask you a question about those in the Rhondda constituency, you could point me to the exact information for each practice.

[104] **Mark Drakeford:** The information should be available practice by practice. We can make sure that Members have a link to—

[105] **Elin Jones:** You could put on the new website the GP practice information on points.

[106] **Mark Drakeford:** We are going to put out practice information at a GP level.

[107] On that point, I would just mention very briefly that it is not just GP practices that have variable performance in relation to sending people in through emergency departments. We know that care homes and nursing homes are probably a bigger part of this picture. In Cwm Taf, to use that example of an LHB, one of the main strands in its plan for this winter has been to work with the five nursing homes within its boundaries that send the most people in through emergency departments and to have extra things in place with them, so that, this winter, their levels of admission come down to those that other nursing homes that manage these things in a different way would have.

[108] **David Rees:** Minister, I am aware that we should be finishing at 11 a.m.; are you able to stay until about 11.10 a.m.?

[109] **Mark Drakeford:** I have a meeting at 11 a.m. with some people from outside the Assembly, but I am sure that 10 minutes would not be a problem.

[110] **David Rees:** Thank you very much for that, Minister. Elin has the next question.

[111] **Elin Jones:** Mae llawer o fy nghwestiynau wedi cael eu gofyn yn barod, ond hoffwn dynnu eich sylw at y ffaith ein bod yn dueddol o siarad am y gaeaf fel ei fod yn unfurf o Hydref hyd at fis Mawrth. Am y rheswm hwnnw, mae'r wybodaeth yr ydych wedi ei roi i ni yn atodiad 1 ynglŷn â pherfformiad yn ystod y gaeaf y llynedd yn ddi-ddorol iawn. Mae'n dangos y *pressure* yn benodol iawn, nid yn y misoedd traddodiadol o Ragfyr ac Ionawr, ond ym Mawrth ac Ebrill, pan wnaeth y gaeaf fwrw o ran tymheredd, ac yr oedd y tywydd ar ei waethaf. Digwyddodd y *spike* hwnnw—neu'r *surge*, fel yr ydych wedi ei alw—ym Mawrth ac Ebrill eleni, yn hytrach nag yn ystod y gaeaf mwy traddodiadol. Rydych wedi sôn am y *surge capacity* yng nghyd-destun gwelyau mewn ysbytai—a bu ichi sôn am 460 o welyau mewn ysbytai—a hoffwn ddeall yn well beth yw'r *surge capacity* yng ngweddill yr NHS. Rydym wedi sôn am wasanaethau GP *out of hours* yn barod, ond beth am GP *in hours* o ran hynny? Beth am y sector llywodraeth leol, er enghraifft, gweithwyr cymdeithasol? Mae'n rhaid cael gweithiwr cymdeithasol ar gyfer pob asesiad cyn i glaf adael ysbyty. Beth yw'r cynllun, felly, ar gyfer y *surge capacity* i wasanaeth yr NHS yn ehangach na dim ond yr ysbyty?

Elin Jones: Many of my questions have already been asked, but I want to draw your attention to the fact that we tend to talk about the winter as if it is a uniform season from October to March. That is why the information that you have given us in appendix 1 regarding the performance last winter is very interesting. It shows the pressure very specifically, not in the traditional months of December and January, but in March and April, when the winter hit in terms of temperature, and the weather was at its worst. That spike—or surge, as you call it—happened in March and April this year, rather than during the more traditional winter months. You mentioned the surge capacity in the context of hospital beds—you mentioned 460 hospital beds—and I would like to understand better what the surge capacity is in the rest of the NHS. We have talked about GP out-of-hours services already, but what about GP in-hours services in that regard? What about the local government sector, for example, social workers? A social worker is needed for every assessment undertaken before a patient is discharged from hospital. Therefore, what is the scheme for surge capacity for the NHS in general, rather than just in the hospital?

[112] **Mark Drakeford:** Diolch am y cwestiwn hwnnw. Wrth edrych yn ôl at y gaeaf diwethaf, roedd y problem gyda'r tywydd ym mis Mawrth a mis Ebrill, oherwydd dyna pryd yr oedd y tymheredd yn isel iawn. Os edrychwch ar y wybodaeth ar gyfer gaeaf diwethaf, gwelwch fod yr NHS wedi ymdopi tan fis Chwefror. Fel arfer, ym mis Mawrth, mae'r NHS yn disgwyl i'r pwysau lleihau rhywfaint ac i bethau wella, ond, y gaeaf diwethaf, dyna pryd yr oedd y problemau mwyaf gyda'r tymheredd.

[113] Mae'r Aelod yn iawn i ddweud bod yn rhaid inni gael *surge capacity* ar draws y system gyfan. Rhoddaf un enghraifft, ac rwy'n siŵr y bydd Gwenda yn gallu rhoi mwy o fanylion. O dan cynllun Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr ar gyfer y gaeaf, bydd gweithwyr cymdeithasol ar gael saith diwrnod yr wythnos. Fel arfer, dros y penwythnos, mae pobl yn aros yn yr ysbyty nes bod trefniadau yn gallu cael eu gwneud, ond eleni bydd *surge capacity* er mwyn cael pobl o'r adrannau lleol yn yr ysbytai drwy gydol yr wythnos. Mae enghreifftiau eraill lle mae'r system wedi cael ei chynllunio mewn ffordd sy'n sicrhau mwy o gapasiti ar draws y system gyfan.

[114] **Gwenda Thomas:** Sonioch am asesiad wrth i glaf adael ysbyty, a chredaf mai dyna un o'r problemau. Ni ddylai'r angen am asesiad atal cleifion sydd yn barod i adael yr ysbyty rhag ei gadael. Yr hyn rydym wedi ei weld yn datblygu yw bod y cynllun gofal yn ymestyn i mewn i'r ysbyty ac yn cael ei adael mewn grym am bythefnos fel nad yw'r cynllun yn cael ei dorri ar ei ben oherwydd bod person yn mynd i'r ysbyty. Mae hynny'n hollbwysig er mwyn ceisio osgoi claf yn gorfod cael asesiad arall pan fydd yn barod i adael yr ysbyty.

[115] Rwy'n gwybod bod gennym feddwl mawr o'r *Gwent frailty programme*, ond mae egwyddor o'i fewn bod peth gofal brys yn gallu cael ei darparu yn y cartref. Yn lle bod y claf yn mynd i'r ysbyty, gall doctoriaid ddod i'r cartref. Mae hynny'n beth pwysig. Efallai y byddai'n help i rannu'r wybodaeth sydd gennym fan hyn ar yr holl brosiectau a'u dylanwad ar y gwasanaeth. Efallai y carai'r pwyllgor gael copi, oherwydd credaf

Mark Drakeford: Thank you for that question. Looking back at last winter, the problem with the weather was in March and April, because that is when the temperature was very low. If you look at the information for last winter, you will see that the NHS coped until February. Usually, in March, the NHS expects the pressure to decrease somewhat and things to improve, but, last winter, that was when there were the greatest problems with the temperature.

The Member is right to say that we have to have surge capacity throughout the entire system. I will give one example, and I am sure that Gwenda will be able to give further details. Under Betsi Cadwaladr University Local Health Board's winter plan, there will be social workers available seven days a week. Usually, over the weekend, people remain in hospital until arrangements can be made, but this year there will be surge capacity in order to get people from the local departments in the hospitals throughout the entire week. There are other examples where the system has been planned in a way that ensures that there is greater capacity throughout the system as a whole.

Gwenda Thomas: You mentioned hospital discharge assessments, and I think that this is one of the problems. The need for an assessment should not prevent a patient who is ready to leave hospital from being discharged. What we have seen developing is that the care plan extends into the hospital and is left in force for a fortnight so that the plan is not terminated because the person is admitted to hospital. That is crucial in order to try to avoid a patient having to have another assessment when they are ready to leave hospital.

I know that we think very highly of the Gwent frailty programme, but there is a principle within it that some emergency care can be provided in the home. Rather than the patient being admitted to hospital, doctors can come out to the home. That is important. It might be of assistance to share some of the information we have here on all of the projects and their influence on the service. Perhaps the committee would like to receive

ei fod yn werth rhannu'r wybodaeth hwn.

a copy of this, because I believe that it is worth sharing this information.

[116] **David Rees:** Thank you for that, Deputy Minister; we would be grateful for a copy for Members.

11:00

[117] **Elin Jones:** Yn gyflym iawn, o ran *surge capacity* y *GP practices*, mae'n fy nharo y gallai'r byrddau iechyd fod yn edrych i gyflogi un neu ddau o *GPs* yn uniongyrchol i fod ar gael yn ystod y cyfnod *surge* jyst i fynd allan a cheisio gweithio yn y gymuned mewn ffordd *proactive* iawn i leihau'r pwysau i ddod â phobl i mewn i *A&E*.

Elin Jones: Very quickly, in terms of the surge capacity of the GP practices, it strikes me that the health boards could be looking to employ one or two GPs directly to be available during the surge period just to go out and try to work in the community in a very proactive way to decrease the pressure to bring people into A&E.

[118] **Mark Drakeford:** Gofynnaf i Dr Robinson a oes enghreifftiau o hynny o gwbl. Nid wyf yn siŵr am *GPs*, ond, er enghraifft, mae'r *Welsh Ambulance Service NHS Trust* newydd apwyntio dau ddoctor i weithio gydag hi dros y gaeaf. Felly, os yw'r *paramedics* yn mynd mas a nad ydynt yn hollol siŵr a ydynt yn gallu delio â pherson neu a oes rhaid iddynt fynd i'r ysbyty, maent yn gallu siarad gyda'r doctoriad, sy'n gallu rhoi cyngor iddynt. Y gobaith yw ein bod yn gallu dweud, 'Gwnewch hyn a'r llall', ac mae'r person yn gallu mynd gartref.

Mark Drakeford: I will ask Dr Robinson whether there are any examples of that. I am not sure about GPs, but, for example, the Welsh Ambulance Service NHS Trust has just appointed two doctors to work with it over the winter. So, if the paramedics go out and are not quite sure whether they can deal with a person or whether they have to be admitted to hospital, they can speak to the doctors, who can give them advice. The hope is that they can say, 'We advise this', and then the person can go home.

[119] **Dr Robinson:** I am happy to comment. Traditionally, health boards have not employed GPs in that way. There are health boards that directly employ GPs; most of them do. They have been used historically to support practices that are in difficulties—perhaps some of the practices that Kirsty talked about, where there is a bit of a heart-sink moment. So, GPs have been employed, but I think that you are right that they have not previously been employed to meet surges in the winter. I am very interested to explore different and innovative ways to use GPs as part of the system. It is probably a bit easier to hire GPs than it is to hire emergency medicine physicians. This goes back to the comments that the Minister was making about a properly blended approach that brings in emergency medicine physicians, care of the elderly physicians, and also GPs. I think that there may be opportunities to do what you suggest, and I am happy to take that suggestion away.

[120] **Mr Flynn:** I would just like to add that I think it is important to recognise that part of the reason for flow inside a system is to try to avoid the creation of the need for a surge. So, this working seven days a week, 365 days a year is really important. The winter plans and the unscheduled care plans of health boards, working with their local communities, are very much about how they try to spread that out over seven days a week, 365 days a year. So, it is not just the peaks that you are trying to meet—it is also about trying to avoid some of those peaks by working in different ways.

[121] **David Rees:** Lynne has the next question.

[122] **Lynne Neagle:** On the ambulance service, the changes that we are waiting for in the

ambulance service will not kick in fully until next spring. The paper from the Government highlights the key role that the ambulance services play in planning for the winter ahead. How confident are you that the ambulance service will be sufficiently resilient, bearing in mind that we have seen some significant drops in performance during the winter in previous years?

[123] **Mark Drakeford:** Thank you. As I tried to say at the beginning, we believe that the ambulance service goes into this winter in a better position than it went into the last one. It is seeing huge numbers of people and seeing them in a very timely way, too. However, we do want to increase its resilience for this winter. The ambulance service is recruiting to all its vacancies, and I have made it very clear to the new temporary chair of the Welsh Ambulance Service NHS Trust, Mike Giannasi, that I expect it to recruit to all its vacancies. It has plans for 82 new staff, paramedics and emergency medical technicians to be in place over this winter. There is the example that I mentioned to Elin of doctors being directly employed by the trust to advise at the scene where you have substantial trauma involved. I think the ambulance service is working very hard to make sure that it is as well prepared as it possibly can be for the winter.

[124] **David Rees:** Darren, you had a small question on electives.

[125] **Darren Millar:** My question is on electives, Chair, yes. To what extent has the Welsh Government done any analysis on delayed elective surgery having an impact on unscheduled care? If someone is waiting for a knee or hip operation and they end up falling because they have waited too long, is that having an impact at the hospital front door?

[126] **Mark Drakeford:** I might ask Kevin, who spends his time looking at these sorts of issues, to respond.

[127] **Mr Flynn:** I have to say, Darren, that I do not believe that anyone has done any analysis, if I am being honest. I do not know how easy it would be to do, either. I certainly take the point that when people are delayed they can place a further burden on the system. It is one of the reasons why we are trying very hard to get back within the recovery of the planned care area. I do not know how easy it would be to gather the data, but, as with many of the questions that you ask, we can always go and try.

[128] **Darren Millar:** Thank you.

[129] **David Rees:** On elective care and the systems, you said that you have your plans in place to look at how we will deal with that, particularly looking at bed utilisation. Have you also included in the plans a request to the boards to look at how they actually operate their systems and whether they have changed their systems of elective operations as well?

[130] **Mark Drakeford:** Yes, of course. I think you will have seen, in the note that was circulated to the committee, that a half-day difference in the length of stay is the equivalent of 350 beds in the system. When the Deputy Minister and I met with Cardiff and Vale University Local Health Board and the two local authorities that lie within its boundaries, they said to us that they had concentrated over the summer—since the end of April—on length-of-stay issues within the Cardiff and Vale area, and that they had specialities where they have reduced the length of stay over the last six months by an average of two days for every patient. That releases huge capacity back into the system. Going back to Kirsty's point, extra beds is one aspect, but, if you can reduce the length of stay or increase day surgery or increase rates of operating on the day of admission, rather than getting people in the day before, and so on, that releases beds back into the system at a far faster rate than simply creating new capacity. So, we are very much alert to the ways in which organising elective care and doing it differently mean that you can do more of what you need to do.

[131] **David Rees:** We have a last question from Kirsty.

[132] **Mr Flynn:** I would like to add a supplementary comment, if I may. It seems to me that, around those areas where we have planned care, over quite a long period of time there has been a big increase in day cases for treatment that would previously have been done with people staying in hospital, and, actually, Wales has a very good track record in terms of the number of people that are now being dealt with as day cases rather than in other ways. So, as well as reducing length of stay, the numbers of people that we can deal with as day cases makes a huge difference, in that they do not require a bed in the traditional sense. We are reducing the length of stay in all of the elective areas quite substantially. Each time that we do a day case, that goes out of that figure, so, in other words, we are still improving the length of stay while the day cases are increasing, which is quite a difficult thing to do.

[133] **David Rees:** Okay. I think that you have answered all of Kirsty's questions, or is that not the case, Kirsty?

[134] **Kirsty Williams:** I appreciate that the Minister has other appointments. If the Minister could write with details of how this 'not a second offer' scheme works, that would be very helpful.

[135] **Mark Drakeford:** I am very happy to do that.

[136] **David Rees:** Well, thank you very much, Minister, for your time and for the extra time that you have given to the committee this morning, and thank you, Deputy Minister, and your colleagues. It is very much appreciated. You will receive a copy of the transcript for correction of any factual errors, and you will supply us with the information that has been identified. Thank you very much for your time.

[137] **Mark Drakeford:** Diolch yn fawr—thank you very much.

11:08

Papurau i'w Nodi Papers to Note

[138] **David Rees:** We have the letter from the Commissioner for Older People in Wales; I hope that everyone has been able to note that.

[139] In accordance with the decision taken under item 3, I now propose that we go back into private session.

*Daeth rhan gyhoeddus y cyfarfod i ben am 11:08.
The public part of the meeting ended at 11:08.*